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# THE UNIVERSITY *of* EDINBURGH

**Bruneian Nurses' Perceptions of Ethical Dimensions in Nursing Practice**

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**Thesis presented in fulfilment of the requirements of the degree of  
Doctor of Philosophy**

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## **DECLARATION**

I hereby declare that this thesis has been composed by me and the research on which it reports is my own work. No part of this thesis has been submitted for any other degree or professional qualification.

Yusrita Zolkefli

## ABSTRACT

**Background:** There has been wide interest shown in the manner in which ethical dimensions in nursing practice are approached and addressed. As a result a number of ethical decision making models have been developed to tackle these problems. However, in this thesis it has been argued that the ethical dimensions of nursing practice are still not clearly understood and responded in Brunei.

**Design and method:** This thesis describes a qualitative analysis into the Bruneian nurses' perceptions of ethical dimensions in nursing practice. Drawing on constructivist grounded theory as a method of inquiry, twenty eight practicing and administrative nurses were individually interviewed. The nurses described how ethical dimensions were perceived in their practice, by means of the difficulties they are facing in the real world of nursing practice; how they have responded to these difficulties, and why they make such responses.

**Findings:** The nurses described three ethical dimensions in their practice, namely 'nurse at work' which illustrates the ethical dimensions within the work environment; 'nurse and doctor' that elucidates the ethical dimensions in the nurse and doctor relationship and 'nurse and patient' which further examines ethical aspects in patient care.

'Taking responsibility' and 'shifting responsibility to others' were identified as approaches that the nurses took in responding to the ethical dimensions with the aim of avoiding the conflict and maintaining ward harmony. These responses provide new insights into how nurses' response to ethical dimension in the ward settings where it puts strong emphasis on the nurses' understanding of responsibility placed upon them as a professional nurse.

'Negotiating ethical responsibility' emerged as a core category within the data which illustrate that nurses' responses to the ethical dimensions form a continuous process,

involving constant consideration of the two types of responses. The core category described that ethical dimensions in the nurses' practice were contextualised in the 'ethical responsibility' that is placed upon them within the nursing organisation.

This thesis has expanded the current theoretical knowledge of ethical dimensions by elaborating on the concerns experienced in nursing practice and the responses individual nurses utilise to negotiate and discharge their ethical responsibilities at work. The study has also extended emphasis to the reasoning and responses that nurses are engaged in, whilst at the same time, negotiating ethical responsibility regarding the context in which they are placed during their working hours. This core category provides a number of possible implications for future research, nursing practice, education and policy, which would facilitate the exploration of ethical understanding for nurses in Brunei, and enable the provision of an ethical environment, so making ethical dimensions more transparent.

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## **TERMINOLOGY**

### **Doctor**

In Brunei, the title of doctor generally applies in two fields; first, in the clinical field where individuals hold medical degree are customarily addressed as doctor by the general public even without having a doctorate degree, and second, in the academic field where the individual holds a doctoral degree. Whilst for clinical consultant and surgeon, they are generally addressed as Mr, Mrs or Miss rather than Doctor.

### **Ward manager**

The title of ward manager refers to a registered nurse who is in charge of a ward in a hospital. The primary role is to manage the day to day running of the ward or unit. They are generally addressed as 'sister', regardless of their gender.

### **Nurse in-charge**

The title of nurse in-charge refers to a registered nurse who is in charge of a ward during a specific working shift.

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# **CHAPTER ONE**

## **SETTING THE CONTEXT**

### **1.1 INTRODUCTION**

In recent years, there has been an increasing interest in the ethical decision making component of nursing practice and this is not a surprise, especially with the suggestion that there is an abundance of moral problems and ethical issues that nurses face in their daily routines (Kapborg and Bertero, 2003; Callister et al., 2009). Unfortunately this has been poorly understood in practice. There has been a continuous discussion on the ethical problems faced by nurses who were confronted with ethical dilemmas, where they are not particularly involved in making decisions. Yet it has been suggested that ethical dilemmas lie within the daily practice of nurses, who therefore have to deal with them, as one of the difficulties that nurses face in their work setting. The participants in this study work with adult patients with diverse medical and surgical conditions, both acute and chronic, which may involve both nurses and patients in sometimes difficult situations.

### **1.2 PERSONAL REFLECTIONS ON THE RESEARCH PROBLEM**

The research problem originated when I first started teaching ethics in 2010 to a group of second year diploma nursing students at a nursing college in Brunei. When asked about the ethical concerns that they encountered in practice, the students' general understanding was restricted to unethical practice, for example: giving a patient the wrong medicine, mercy killing and the issue of informed consent. These 'medical ethics' or 'bioethics' examples, rather than nursing ethics, resulted in most of the students dismissing any involvement in making such decisions. This raised an interesting topic: the issue of the gap in the ethical preparation of these nursing students, which results in them lacking the confidence to be ethically sensitive practitioners (Weber 1992).

The students also associated their cultural and religious values with their ethical reasoning for solving their ethical concerns. For example, the issue of euthanasia

and abortion were perceived from a religious perspective, and not as a moral issue. Therefore, reflecting on the values that predominate in the culture that the nurses' practise is a requirement for ethical thoughtfulness.

Seven years ago, the Nursing Board for Brunei Darussalam (NBFB) issued two type of documents namely 'Code of Professional Conduct' (Nursing Board for Brunei, 2010) and 'Code of Ethics' (Nursing Board for Brunei, 2010) and 'Standards of Practice' (Nursing Board for Brunei, 2010). With this milestone, it makes me wonder if ethical dimensions in nursing practice are now being taken seriously by nurses and the nursing profession.

### **1.2.1 Context for the study**

This research involved an understanding of ethical concerns and ethical reasoning of nurses in Brunei, which form the ethical dimension in nursing practice. The subject of ethics has been taught to the nurses, whilst students at the College of Nursing, a subject which aims to enable them to develop appropriate awareness and attitudes on ethical practice in addition to acquiring knowledge and to use ethical decision making skills. Since ethical concerns were thought to be embedded in the daily practice of nursing, one of the earliest steps in the research was for the participants to describe the difficulties that they faced in practice. The approach used to gather the data involved holding semi-structured interviews with twenty-eight nurses in three hospitals in Brunei. Each interview lasted 60-90 minutes.

### **1.2.2 Research aim and questions**

This study has set out to explore how Bruneian nurses define ethical concerns they meet in everyday practice in the medical surgical wards of three Brunei hospitals. By understanding the ethical dimension of nurses' practice in healthcare settings, nurses may gain a better appreciation of that dimension and recognise how it influences practice. The research questions that this research sought to answer were:

- (1) What is the most difficult situation you are involved with in the ward setting?



- (2) How do you respond to that situation?
- (3) What are the reasons for your responses?

### **1.3 THE STATE OF NURSING IN BRUNEI**

#### **1.3.1 Political and historical background of health care in Brunei**

##### **1.3.1.1 Brunei and its population**

Brunei, small in terms of both area and population, is an independent sultanate on the northwest coast of the island of Borneo in the South China Sea. Brunei was a British protectorate from 1888 to 1984. It covers an area of 5765 square km, and is divided into four districts: Brunei Muara, Tutong, Belait and Temburong. The head of state, the head of government and the supreme executive authority is His Majesty the Sultan of Brunei, and he also holds the defence and finance portfolios in the Cabinet and is the supreme commander of the Royal Brunei Armed Forces, the inspector-general of the Royal Brunei Police Force, and the supreme head of religious affairs in the sultanate. In relation to the freedom of the press and expression, the existing law is in place to ensure the existence of peace, and the stability and security of the country, are maintained. However, there are restrictions on freedom of speech, including the fact that it is an offence to criticise the government and the royal family; there are also limits on the freedom of the press. Local newspapers such as the Borneo Bulletin and the Brunei Times exercise self-censorship on political and religious matters, but they do have letter columns in which members of the public often air their views on various matters. In 2004, with the reconstitution of the Legislative Council, Brunei was committed to allowing people to be more involved in the decision-making process. It is worth mentioning that His Majesty also practises informal consultations by meeting people when he visits villages, praying in different mosques on Fridays and opening his palace for three days during Eid. On these occasions, people often deliver their requests and complaints in envelopes and these are attended to immediately.

As of 1 January 2016, the population of Brunei Darussalam was estimated to be 441,201 people, with only 15,499 persons above 64 years old (7,553 males / 7,946 females). The demographic structure is essentially that of a young population. In 2015, life expectancy at birth was 73.9 years for males and 78.5 years for females. The birth rate increased slightly from 16.1 in 2008 to 16.3 per 1000 population in 2009, and the death rate was 2.9% per 1000 population in 2009, with an increase from 2.7% in 2008 (Ministry of Health, 2009). Brunei is almost entirely free of major communicable diseases.

In 2014, the four leading causes of death, which accounted for 50% of the total number of deaths, were non-communicable diseases, namely cancer, heart disease, diabetes mellitus and cerebrovascular diseases. Cancer was the prime cause of mortality with the most common types being those of a respiratory nature for males and those of both a breast and respiratory nature for females. The second most prominent cause of death was heart disease with ischaemic heart disease being the most common (Ministry of Health, 2012).

#### **1.3.1.2 Socio-economics and structure**

Brunei Darussalam has a multi-ethnic population, with Malays being the predominant ethnic community at 66.3%, the Chinese constituting 11.0% and other races as well as expatriates make up the rest of the population. Islam is the official religion, but it is also a way of life for the people; non-Muslims can practise their religions in peace and harmony. This means that Brunei Darussalam society revolves around its Malay culture and the Islamic faith; in addition, the concept of a large extended family forms the foundation of the social fabric of society and a social safety net. The official language is Malay, but English is widely understood. Meanwhile the country has a low tariff regime and no capital gains or personal income tax (Brunei Economic Development Board (BEDB)). Because of its oil-based economy, Brunei is wealthy and the majority of people enjoy a relatively high standard of living for Southeast Asia, with subsidies

being given for food, fuel and housing, together with low interest loans for government employees, and other benefits. Data on poverty in Brunei is almost impossible to find. In October 2009, His Majesty the Sultan of Brunei, in his speech declared that “Brunei is now justified to be labelled as ‘free from poverty’” (The Brunei Times, 2009).

Meanwhile, formal education is given free to all Brunei citizens who attend government schools and institutions. These students are also given free text books, transport and light meals and also free hostel accommodation is provided for students from rural areas. For those who enter higher institutions or technical colleges, monthly expense allowances and free accommodation are provided by the Brunei government as a form of incentive and assistance.

In terms of the social structure, the family is the foundation of Islamic society. The man is considered the head of the family and the primary role of women is to be good wives and good mothers. Muslim patients understand that illness, suffering and dying are part of life and a test from God (Rassool, 2000). Caring is a natural outcome of loving God and the Prophet (Peace be upon him). Showing respect and compassion for elderly people and helping those who are powerless, orphaned, wounded or ill are merits and are encouraged in Islam. Islam does not prohibit Muslim nurses and other healthcare professionals from caring for both Muslim and non-Muslim patients. However, physical contact between a woman and a man who are not close relatives is regarded as a sin.

The conventional, normative structure of Islam and the patriarchal South East Asian culture, which rests on male superiority, shape the family and social life of Brunei. The social life is mainly collectivist. In most families, respect for elderly people according to the hierarchic positions and obedience to parents, is encouraged. However, it is relatively common, when these elderly are ill, that children and particularly the eldest become influential in the family.

### **1.3.1.3 Historical and contemporary health care system**

The health services in Brunei were formed in the early twentieth century, when Brunei faced the spread of cholera and smallpox. Peter Blundell (1923) in his book 'City of Many Waters' illustrated Brunei at that time as being in a very bad situation, with families mourning the loss of one or two family members. Brunei also did not have a doctor and had to rely on medical services from Labuan, which was part of Brunei until 1846. As a result of this lack, the Labuan based doctor visited Brunei from time to time. The first medical doctor in Brunei was appointed in February, 1929, with the title of residential medical officer. In the early 1930s, several hospitals were built. Other developments included the appointment of a government midwife, the operation of a maternity and children's clinic in order to reduce the number of deaths, new hospital buildings and mobile clinics which were made available throughout the country. Arguably, the medical and health conditions in Brunei were transformed and improved over a 40-year period. Nonetheless, when the Second World War had begun, almost all of the hospitals were utterly damaged, with exception of one hospital which was equipped with an x-ray machine.

When the war was over, the medical services were provided by Australian troops through temporary hospitals. The 1950s were regarded as the revival period, with a new hospital (referred to as the best in Borneo) being built in 1952 with 150 beds. Nurses were also trained by experienced nurses from the World Health Organization (WHO) who came to help. By the year 1954, the country had a total of five doctors and 18 clinics in operation.

In the present health care system, citizens of Brunei are charged only one Brunei dollar for their medical and health care in all government hospitals, health centres and health clinics throughout the country. Medical care for those aged below 12 years is provided free of charge. With the government providing and paying for comprehensive health care services, this means that there is a limit stipulated for private insurance for citizens

and permanent residents. For others, a nominal fee is charged, while employers of foreign nationals typically purchase health insurance locally, unless the employer is a multinational company (for example, a bank or oil company), in which case the corporation will provide health insurance through an international insurance company (Ministry of Health, 2012). Such a large network of health centres and clinics located throughout the country provides primary health care services. However, in remote areas these are difficult to access by land or water and primary health care is provided by the Flying Medical Services. Patients who require specialised treatment that is not available in the country are sent abroad, for example to Malaysia or Singapore, where expenses for its citizens are borne by the Brunei government.

To date, there are four government general hospitals, fifteen health centres, fifteen health and maternal and child health clinics, three travelling health clinics and four Flying Medical Services teams for remote areas. The Ministry of Defence also operates nine medical centres that mainly provide services for its personnel and their families. In addition to the government hospitals in each district, there is one semi-private hospital called the Jerudong Park Medical Centre (JPMC). This centre is a specialist hospital that offers various clinical services that may or may not be available in the government hospitals. On the same site is the fully private Gleneagles Park Centre, which provides sophisticated and comprehensive cardiac and cardiothoracic services, such as open heart surgery. This centre also receives referral patients who have been diagnosed by government hospitals for treatment. There is also one private health centre, the Panaga Health Centre, which is only for the employees of Brunei Shell Petroleum (BSP).

The main government referral hospital in the country is the Raja Isteri Pengiran Anak Saleha (RIPAS) hospital, situated on a 32-acre site about 0.8 km from the heart of the capital. This has been the main teaching hospital for many years. The second largest hospital, Suri Seri Begawan (SSB) hospital in Belait district, is recognised as a teaching hospital. In 2014, there were 528 doctors and 3026 nurses in the country.

A large percentage of the country's budget is allocated to the Ministry of Health each year as a measure towards creating a proper infrastructure for the health system and health services. In the Ninth National Development Plan (NDP) (2007-2012), an estimated total of B\$149 million was allocated for medical and health services, which is 1.6% of the NDP's total allocation. Several areas were emphasised, which consisted of improvements in hospital facilities and services and improvements in primary health care services, amongst others. The Ministry of Health has also now been able to implement well-coordinated programmes and projects that can be accessed through a common goal, which is to improve the quality of health and well-being in Brunei Darussalam.

### **1.3.2 The state of nursing practice**

#### **1.3.2.1 The workforce**

Nursing is a women's profession in Brunei, and women's status is multidimensional, affected by religion, culture, social, political and economic factors. In Brunei, female nurses comprise the largest nursing workforce as well as a large proportion of the health care workforce, with a small number of male nurses. Approximately two-thirds of nurses work full-time in the government (public) sector, (part-time jobs are uncommon) and are generally required to retire upon reaching the age of 60. Graduates are often bonded to the Ministry of Health or a private hospital for a period of time, following their initial preparation, in recognition of the employer's contribution to the cost of their education.

In 2008, the Acting Director of Nursing Services stated in the Brunei Times newspaper that health centres and hospitals throughout the country were said to be facing a shortage of nurses with 426 posts, ranging from top level director to midwives, still vacant (The Brunei Times, 2008a). He suggested the problem was not because of a shortage of nurses to fill in the posts; rather those available were not suitably qualified to fill those positions and cope with the nation's growing demand for healthcare service professionals.

The large nursing workforce primarily comprises staff nurses and assistant nurses, and they have different qualifications, roles and responsibilities. With the presence of many local nurses in the 1990s, there was a gradual falling off in terms of the numbers of expatriate nurses, either as ward managers or staff nurses. According to statistics in 2014, there were a total of 2660 local nurses and 366 expatriate nurses. In total, there are 3026 nurses, that is, a ratio of one nurse to every 148 persons in Brunei. The Ministry, however, in the last few years, has been employing a number of nurses from the Philippines to work as assistant nurses.

The nurses are paid accordingly (based on the old scheme of nursing), as follows in each month: a nursing officer receives B\$2100- B\$3600, senior staff nurse B\$2300- B\$3400, assistant senior staff nurse B\$1500-B\$2600, staff nurse \$1500-B\$2200, assistant nurse special grade B\$1400-B\$2000 and assistant nurse B\$630-B\$950. In 2013, a new nursing service scheme was announced which offered better opportunities for career progression for local nurses. In this new framework they will be able to attain the highest level, as a 'nurse practitioner', which attracts a monthly salary of B\$8000.

The nurses' working patterns are categorised into three types: morning shift (7am-2pm), afternoon shift (2pm-10pm) and night shift (10pm-7am). The office hours are 7.45am-12.15pm and 1.30pm-4.30pm. There are no overtime or long day shifts.

#### **1.3.2.2 Department of Nursing Services**

The Director of Nursing Services (DNS) is under the management of the General Director of Medical Care Services. Meanwhile, the Brunei Nursing Board is under the care of the DNS. The hierarchy operates as follows: the DNS, a principal nursing officer (professional and services), two principal nursing officers, eight senior nursing officers, 58 nursing officers, 98 senior staff nurses, 1512 staff nurses, 33 senior assistant nurses, 54 assistant nurses special grade, 281 assistant nurses and 20 assistant nurses (trainees). In terms of educational qualifications, so far there is only one nurse with a

doctoral qualification, and he was the former Director of Nursing; however, there are several nurse clinicians with master's degree qualifications. In 2014, one midwifery lecturer was awarded a doctorate.

There are several units that fall under the Department of Nursing, including the Nursing Board for Brunei and Quality Unit. The Nursing Board for Brunei (NBFB), or the Board, is a regulatory body established under the Nurses Registration Act (Attorney General's Chambers, 2014) and Midwives Act (Attorney General's Chambers, 2012) as postulated in the laws of Brunei. The Board came into force in 1988. As in other countries, the Nursing Board's main roles are to govern and regulate the practice of nursing and midwifery in the country; the actual roles of the board remain misunderstood today. For many years, the Board was often mistaken for a place to manage the annual bonuses, as one example. Despite the Board being held directly under the DNS, who is also the registrar of the Board, it is still not an independent statutory body, with only a very limited range of power and influence in terms of shaping the nursing profession. In most cases, complaints about nurses' alleged misconduct do not reach the Board; as such matters are mostly dealt with at hospital level.

In 2010, however, the presence of the Board was progressively being felt with the publication of three documents: the code of professional conduct; the code of ethics; and the code for the standards of practice. These three documents are disseminated to hospitals, health centres and clinics throughout the country. At the moment, the Board is in the process of compiling a system for nurses' registration based on the Nurse Registration Act (Attorney General's Chambers, 2014). For a qualified nurse, this Act does not play any central role, except to emphasise that they have to register their names upon commencing employment with the Ministry. However, although the Act (Attorney General's Chambers, 2014) clearly mentions that registration is only valid for a certain number of years; there is no renewal of licences or any updating on registration. It is assumed that the evidence for good character, satisfactory performance or possession of adequate knowledge and experience is gathered by other departments. For example,



this data gathering is carried out through the completion of an annual performance appraisal which, in most cases, does not provide a full detailed representation of the ability to be a safe and competent nurse. The appraisal is often seen as ‘time to get it completed; otherwise you would not get your end of year bonus’. Moreover, the loose mandatory requirement of a minimum of twenty credit points that a nurse has to acquire in one year, through attendance at nursing related lectures or seminars, does not guarantee that the nurse has updated their knowledge and skills. The non-existence of any forms of examination, to ensure their licence is continued, arguably influences the quality of nursing practice exhibited in Brunei’s hospitals and clinics. It is rather startling that the professional development of nurses, in terms of identifying the scope of practice, is assigned to two separate divisions: the Nursing Monitoring and Quality Unit, which has no affiliation with the Board, and a special committee that is reviewing the scope of practice. A standard national body under the Nursing Board prerogative to develop such framework on scope of practice may suffice.

#### **1.3.2.3 Nursing as a career**

Before the establishment of the JPMC and Gleneagles private hospitals, the majority of the nurses worked in government (public) hospitals, employed by either the Ministry of Health or the Ministry of Defence, or they worked under the BSP Company. Once awarded with a diploma, they will be enrolled onto an internship programme for the duration of a certain period in their chosen areas, but may or may not end up working there on a permanent basis. In Brunei, the nurses work on a full time basis, and they either work on shift patterns or an office hour basis.

In general, nursing has been perceived by many as a quick employment guarantee, compared to university graduates who seem to have to compete for employment. However, this all changed after 2002, when the Ministry selected new graduates to be employed first, based on good examination results; the rest would have to wait several months before eventually being employed, after interviews were carried out. This precaution is possibly an effort to ensure that the new nursing employees are

prepared to work as real nurses. Such efforts made by the Ministry have caused angst among new students and their parents, judging by what can be read in the newspapers. Nevertheless, Brunei has taken a strategic decision to increase the number of students undertaking nursing courses and thereby increase the supply of new graduates. Whilst increasing domestic supply has been favoured over other strategies, active employment of expatriates' nurses is still taking place to compensate for personnel shortages.

In the last few years, there has been a relatively slow but encouraging increase in the presence of nurse-led clinics. Three areas of nursing have been active in terms of promoting such clinics in the area of cardiology nursing, where a number of clinics or units have been set up for the prevention of cardiac disease and managing heart rhythm disorders and heart failure. The RIPAS hospital's division of respiratory medicine (DORM) has also started up a similar establishment for asthma and chronic obstructive pulmonary disease (COPD). Another clinic is in the form of the Child and Adolescent Team, where nurses provide counselling and evaluated nursing intervention programmes and take part in cross-disciplinary treatment. Meanwhile, in early 2007, a new course was introduced by the Ministry of Health that consisted of training fifteen nurses for six months and, upon completion of the training, these nurses were to be known as primary care nurses. The introduction of such a course is seen to be meeting the needs of the increased number of patients coming to the clinics, together with the small number of doctors present, causing the Ministry to take steps to train nurses in specific skills. After the course, the nurses are able to treat minor ailments and also to prescribe certain medicines. In April 2008, a ceremony was held and a total of fourteen nurses were observed after receiving training on the basic healthcare service, after which they became primary care nurses. Based on my personal experience of being treated by a primary care nurse, they seem professionally confident, but research needs to be carried out to analyse the experience of nurses, doctors and the community on this matter, to ensure that the new role can be further enhanced. Another new role that was introduced in 2009, was when a total of thirteen nurses from the first and only

cohort received certificates for completing a three-month course, which allows them to carry out Pap smear examinations.

#### **1.3.2.4 Nursing Board for Brunei Darussalam**

The Nursing Board for Brunei or the Board is a regulatory body established under the Nurses Registration Act (Attorney General's Chambers, 2014) to regulate the practice of nursing in Brunei Darussalam. The board has no public representatives. There is however, in the recent cases where nurses' and patients' welfare was subjected to increasing levels of challenge, criticisms and questioning, via the legislative council meeting which is held on an annual basis.

To date, the Board's power and authority are limited to issuing letters of conduct to foreign nurses who wish to work somewhere else after working in this country for several years. Its authority is also limited to advisory role on cases of misconduct, and has no power to remove persons from the register for what was judged to be professional misconduct; any such action would be done via the Public Service Commission (SPA). In discussing the purpose of regulation, the International Council of Nurses (ICN) (1998) stated that the organization responsible for regulating the profession must be innovative rather than passive. To suggest that the Board is passive in nature might be slightly unfair; however, there is a pressing need to address any such passivity soon, particularly when the professional conduct and ethical codes have been distributed widely throughout Brunei. Furthermore, the majority of nurses appear to have a poor and elusive understanding of the function of the board. There appears to be a popular and common assumption held by the nurses that the Board should play an aggressive role to support them. The Board, however, strongly feels that the ward managers play a pivotal role in managing any ethical concerns or unethical behaviour of the nurses. Meanwhile the 'infancy' nature of the Board suggests that there are a number of areas that need to be addressed, particularly the absence of any formal procedures. The latter point makes it problematic, almost impossible, to affirm its power and authority. As

a result, such power to remove and suspend a nurse's registration is managed by the Public Service Commission. Reg Pyne (1998, p.13) who was the United Kingdom Central Council's (UKCC) first Director of Professional Conduct and Regulation in 1982, proposes that:

*Just as the register becomes a meaningless device if appropriate control is not exerted over admission to it, so also it has no significance if the regulatory body has no power, and no procedures in place, whereby, in the public interest, it can remove or suspend a practitioner's registration and, by that means, prevent a nurses from practising in their profession*

In Brunei's context, this matter is relatively delicate in nature. There is possible speculation for these sensitive issues; that is, the direct administration of the Nursing Board cascades under the jurisdiction of the Department of Nursing Services, and subsequently is managed under the authority of Director General Medical Services. To suggest that the Board is relatively inactive might not be just.

On the hand, there is also a statutory body for nursing that specifies the content and outcomes of a programme leading to the status of registered nurse, or for a higher level of nursing qualification (Boore and Deeny, 2012). In Brunei, the only legal framework for nursing exists in the Nurses Registration Act (Attorney General's Chambers, 2014) which requires that 'as a condition of admission of any person to the Register that person shall have undergone the prescribed training, and shall possess the prescribed experience, in the nursing of the sick'. The term 'prescribed training' seems to give full control to those responsible for the training of nurses for determining the competencies to be achieved, as well as the knowledge and skills required to demonstrate these, as they are deemed appropriate. This is not a surprise at all since there is only one institution that is responsible in the training of nurses. The act was amended as Nurses Registration Regulations 2014 (Attorney General's Chambers, 2014) were enforced in March 2015. Under the act no one is allowed to employ individuals for nursing services unless they are registered.

Regarding entry to the registry, Pyne (1998, p. 13) points out:

*The professional register is a meaningless device unless inclusion in it is the result of appropriate education and training in an approved institution, at the end of which the individual has demonstrated possession of the appropriate knowledge and skill to be permitted to embark on a career as a professional practitioner.*

In Brunei, all local nurses are registered by the Nursing Board for Brunei Darussalam (NBFB) following completion of nursing programmes from the only nursing institutions in the country. This means that there is a direct control over that part of the route to the register. In these cases, the application is subjected to a detailed accreditation process by an independent accrediting body, namely the Brunei Darussalam National Accreditation Council (BDNAC).

### **1.3.3 Nursing education**

#### **1.3.3.1 Early nurse education**

It was in the early twentieth century that a government dresser was appointed and was seen to play a very significant role in providing health services; in fact, government dressers are also recognised as pioneers in health care in Brunei. The government dressers act as doctors, nurses and allied health care professionals, all in one. Their roles include treating minor ailments, wounds and injuries, giving vaccinations and educating the public in health related matters, as well as dispensing medications. When the Second World War ended, nurses were trained by experienced nurses from the WHO. The first school of nursing in Brunei that provided midwifery and nursing education was established in 1957. At that time, many nurses were also sent abroad for training. A year later, the first Brunei Malay was appointed as a nurse and midwife.

#### **1.3.3.2 Nursing programmes**

A nursing college (Pengiran Anak Puteri Rashidah Sa'adatul Bolkiah College of Nursing) was established in 1986, where it offered a Certificate in Nursing. In 1991, the programme was upgraded to a Diploma in Nursing after a constant evaluation and improvement period. Since its introduction, with only 23 students in the first cohort,

the college has gradually attracted more students so that there is an accumulative number of not less than 100 students per cohort and it has produced a total of more than 2000 qualified nurses.

To be eligible for the course, candidates are to have a minimum of four O Levels with priority given to English, Mathematics, Science and Bahasa Melayu (the Malay language). The diploma is a three-and-a-half year course, with the curriculum being based upon a content-based approach; it embraces the principle of 50% theory and 50% practice. This approach is one of the three approaches that Uys and Gwele (2005) identified. The content-based approach is the commonest and most traditional curriculum approach used in nursing education. The teaching staff decide upon, and then deliver, the content and the major teaching method is lectures with some discussion or seminar sessions. Over-teaching and possibly less relevant teaching and learning are an obvious result, with the vast amount of medical and surgical cases that have to be covered during the second year. Being one of the products of the curriculum, I can still vividly remember how my study group had to meticulously understand and 'memorise' hundreds of illnesses for a three-hour written examination.

Students begin the first year with anatomy, physiology, sociology and psychology, to name a few areas, with the incorporation of the national philosophy of the Malay Islamic monarchy as a compulsory subject. In the second year there follows medical surgical nursing; in the third year speciality nursing with two elective modules (such as emergency nursing, paediatric nursing, intensive care nursing) and the final semester is for the management modules. Teaching and learning take place in the form of lectures, independent reading and group discussions and presentations. The language of education for all nursing programmes is English; the educators are generally Western educated. Nursing curricula are heavily influenced by the British and Australian nursing programs and the textbooks are in English. As a means of student support, each student is allocated to an academic, who acts as a personal tutor and whose responsibility in this role is to facilitate the student in the successful completion of their programme.

Meanwhile clinical skills are taught in the skills laboratory and through continuous teaching in the clinical areas by the assigned mentors or other qualified staff. Normally, the first clinical placement begins as early as the first semester. Junior and senior students often receive support and guidance from academic teachers who visit them weekly during the placements. However, most of the teaching and learning are carried out by the assigned clinical mentor or staff nurse, who often has two or more students assigned to them. In addition, the duty rosters of the students, which are pre-determined by the lecturers, do not help in maximising the learning of the students. Some students have the privilege of working alongside their mentors in some shifts, while others have to work with nurses, who may or may not be prepared to teach or who may not have sufficient work experience, with some of them regards the students as being an extra pairs of hands. This is not new or surprising, particularly with a workload that is so demanding and considering the shortage of nurses working in the ward. Such pressure therefore potentially prevents adequate learning taking place in practice.

On the other hand, the assessments vary with written examinations, written coursework of not more than 2000 words, objective structure clinical exams (OSCEs), which were only introduced in 2001, and continuous clinical assessment during placements by mentors or clinical teachers using the students' clinical logbooks. The final assessment is a 6000-word written research proposal (dissertation format) and written examination.

The college began to offer other programmes such as the post-basic diploma, now known fondly as the advanced diploma. In 2003, the college offered a one-year full time post-basic diploma course with a 40% theory and 60% practice programme. When it was first announced, the Board of Management of the College of Nursing approved a scheme by which students who had completed their Diploma in Nursing could continue their studies in various advanced courses. As a result, the first 23 graduates selected have completed this scheme and were awarded a double diploma in 2004. The course also accommodates those who have at least three years' work experience. It is worth

mentioning that programmes such as conversion courses were introduced, where a two-year full time course for in-service assistant nurses is offered in order to upgrade them to staff nurse status.

For their financial support, all local students are paid allowances on a monthly basis by the Ministry of Education, with the allowances increasing as they proceed with the programme. Some students are fully sponsored by Brunei Shell Petroleum (BSP), while non-Bruneians have to pay for their tuition fees and are not entitled to educational allowances. There are also a number of international students from Southern Thailand, the Caribbean and Pakistan (to name a few places), who are under the funding of the Brunei Government and international organisations such as the United Nations Educational, Scientific and Cultural Organization (UNESCO). In 2007, for the first time, the Gleneagles JPMC Cardiac Centre announced the sponsorship of a few students. Unlike BSP, the students funded by both the Ministry and Gleneagles JPMC have to be employed by the respective organisation for an agreed number of bond years.

In the year 2010, the Diploma in Health Science (Nursing) was started to replace the Diploma in Nursing and there have been no more than 40 students in each cohort. In recent years however, with the demand from the Ministry of Health, the numbers have increased. The programme is now offered as a three-year course, with the teaching and learning being slightly different from those of the previous Diploma in Nursing. Teaching and learning take place in numerous forms, such as modified lectures, guided study, problem-based learning or evidenced based learning, independent reading and group discussions. Another significant difference to the old diploma is that there is an 18-month paramedic course during their third semester. In 2015, however, the new Diploma programme was moved under the management of Brunei Polytechnic, and was no longer under the University's administration.



Meanwhile, unlike the first few years of the advanced diploma course, where fresh diploma graduates enrolled in this programme, the trend has rapidly changed, as most students are now nurses with several years of work experience. Furthermore, a decline in the number of applicants has forced some of the programmes to be cancelled. Based on several personal communications with the nurses, a number of them have expressed an interest in enrolling in the programme; however, the difficulty in obtaining support from the in-service scheme (full salary throughout the programme) has been one of the many reasons for them not pursuing this. As to date, there is no updated news on the conversion courses where assistant nurses undergone two years of upgrading themselves to staff nurse status, since the last enrolment of the cohort (seventh intake) was in 2007. The training for the Certificate in Nursing is now managed by the Ministry of Health, under the Continuing Nursing Education Centre (CNEC).

In 2009, the College of Nursing was merged into the main national university, Universiti Brunei Darussalam (UBD). A four-year bachelor of nursing course was introduced as part of the GenNext degree programme with modules of both major core and breadth modules. It also offers the Discovery Year module, where students have the opportunity to spend a minimum of six months to one year of clinical/non-clinical attachment abroad or local. To be eligible for the course, applicants must possess at least six O levels, a score of 6.0 on the IELTS (English test) and a pass in the multiple-mini interviews (MMIs). Unlike the previous traditional method of interviewing the applicant, the MMI is relatively exciting because the applicant has the opportunity to demonstrate their knowledge and understanding about basic nursing, by going through each section of the interview set, with the examiner scoring them accordingly. The first cohort consisted of only four students, but last year there were eighteen students in the seventh cohort. Students may be either qualified nurses or students who have just finished their GCSE A- levels; their ages range between eighteen to forty years old. The course is carried out in the English medium.

Using Uys and Gwele's (2005) three broad approaches to curriculum design and delivery, the course is constructed with a combination of the content-based approach throughout the curriculum, with the process-based curriculum approach at the beginning. This means that, throughout the four-year programme, the major teaching method is lectures with some discussion or seminar sessions, and the teaching in nursing skills takes place in the clinical laboratory, as well as in clinical placements. The process-based curriculum, however, appears to have been introduced during the first and second years of the course, where the learning is student centred in nature. This can be seen when the majority of the learning is carried out in the form of problem-based learning (PBL) and self-directed learning (SDL), amongst other methods. When it first took place, students had a combined PBL session with students from other disciplines, such as midwifery, biomedicine and medicine, as one way of promoting inter-professional education (IPE). However, after a year's trial, it was then thought best to have a separate session with only midwifery and nursing students together. One of the possible explanations for this move is the different learning objectives as well as the depth of the subjects covered. In semester seven, students have elective placements in a specialised clinical settings, which is similar to the Diploma in Health Science programme. Meanwhile clinical skills are taught throughout the programme in the simulation skills laboratory, direct patient care settings and the community. The students are assessed similarly as to how they are assessed on other nursing programmes. A year after its inaugural cohort, a shortened pathway of two to three years programme was offered for those who are eligible for credit-transfer for modules already completed in their advanced diploma.

On the other hand, the teaching team varies. Nurse teachers in Brunei did their nursing training abroad. They are, without doubt, heavily influenced by the western theories and principles. They shaped the content of nursing education and training programmes. The representatives from the Ministry of Health have some parts to play, even though it may be probably a minority voice in matters related to the regulation

of the profession. Nevertheless, there was a good combination of local and expatriate nurse educators from the UK, Singapore and Africa, to name a few places. With the college offering its local students many opportunities to study for degrees, most of these former students return to the college and joined the teaching team; each with their own speciality areas such as adult nursing, mental health nursing, children's nursing and midwifery. Academics primarily develop and provide the theoretical aspects of the programme, and they also teach clinical skills in the college in preparation for clinical placements. They also visit students in clinical areas to ensure the application of theory into practice. While clinicians are involved in the mentoring of students in clinical areas, they are also, when possible, invited to contribute to classroom teaching. Furthermore, when possible, speakers from relevant ministries, as well as voluntary and private organisations, are invited to contribute to the teaching and learning of future nurses.

Nevertheless, since the merging of the two institutions, one of the many new scenarios witnessed is the presence of several expatriate nursing lecturers with doctoral qualifications, who are subject specialists, contributing to some of the subjects underpinning nursing. Within a year, several lecturers with doctoral and professorial-level qualifications from other disciplines have become part of the teaching team, which is seen as a way of increasing the standard of nursing education in Brunei. Meanwhile, more local lecturers are being given the opportunity to pursue their masters and doctoral studies.

During the nursing college period, one way of ensuring the academic standards for, and quality of, the programmes are on a par with the rest of international nursing education, is to form partnerships, in this instance with University of Wales College of Medicine (now known as Cardiff University). One of their key roles is reviewing and moderating the marking of examinations and coursework to ensure equity and consistency and an appropriate standard of internal marking (The Quality Assurance

Agency for Higher Education (QAA), 2004) cited in Boore and Deeny (2012). With the merger, the new curriculum and all revised diploma programmes are subject to a series of consultations with academic representatives of the School of Nursing and Midwifery, Monash University (Australia).

Meanwhile the Ministry of Health has also been sending a number of nurses to study for their degree courses in the UK and Australia, where the courses would heavily emphasise specialised nursing areas such as respiratory nursing, cardiac nursing, infection control nursing, mental health nursing, children's nursing and renal nursing. So far, upon completion of their studies, these graduates have played the roles of clinician and ward manager with a few taking up positions in the nursing administration department. Apart from the long-term educational plan, the CNEU has been vigorously organising short courses (local and abroad), as well as symposia, lectures and seminars on a regular basis throughout the country.

#### **1.3.3.3 Ethics in nursing**

Using the available curriculum for Diploma in Nursing, I was able to examine how ethics was incorporated within the curriculum. In Semester 2, the Islamic aspect of ethics was also integrated under the subject of Islamic Religious Knowledge (IRK). The biomedical issues such as organ transplants and brain death were stated within the curriculum (Pengiran Anak Puteri Rashidah Sa'adatul Bolkiah College of Nursing, 2001). The modes of teaching include lectures, practice and demonstration whilst the students were assessed through continuous assessment. Given the issues described earlier, this was rather odd because students were only introduced to the principles of ethics in Semester 4, whereby the only subject called legal and ethical issues was taught. The unit was to provide the knowledge and skills regarding the legal and ethical issues in nursing, which should then enable the nurse to apply knowledge and skills in their professional role in relation to moral decision making (see Appendix A).

In the present curriculum for Diploma in Health Sciences, the subject of ethics was rather invisible (the catchphrase is integrated) within the curriculum. This however,

may not be sufficient in achieving the essence of nursing ethics as ethics is taught alongside nursing subjects, and not a single subject. For the Bachelor programme, this module 'Law and Ethics for Health Professionals' is offered as both a major core for nursing students and an external breadth course which carries 2 modular credits, involving 14 weeks of teaching and learning. An external breadth course refers to a module that is offered to non-health professional students. The students are being assessed through an oral presentation (40% weighting) of various topics of ethical issues, and this is followed by a 2,500 word written assignment (60% weighting). The teaching team responsible for the topic of ethics consists of at least two teachers, and this proves to be deemed deficient in addressing the concerns raised in Section 2.3, where the teaching of ethics and application of ethical knowledge to the clinical experiences of nursing students requires the teachers to have ethical knowledge and skills. Ann Hamric (2002) echoes this concern when she suggests that many clinical faculty members lack confidence in their knowledge of ethics or the process of ethical decision making and find it difficult to model the integration of ethical theory and practice.

#### **1.4 ORGANISATION OF THE THESIS**

Chapter 1 sets out the context of this study, where I will write my personal reflections on the research problem, followed by the research aim and questions. The chapter also review the health care context in Brunei, where the research was undertaken. This is followed by a review of the nursing practice and nursing education in this country, including the role of the Nursing Board in Brunei Darussalam. It also encompasses the teaching of ethics and the ethical practice in nursing from a Brunei context.

Chapter 2 presents the first part of wider literature review on the theoretical underpinning for studies on ethical practice. This includes a critical review of studies on ethics in nursing and the teaching of ethics which identify a gap in the existing knowledge of the ethical dimension in practice. It also reviews ethical practice in nursing, ethical

distress and moral strength, to form the research context. This is followed by the second part of literature review.

Chapter 3 and 4 illustrate the research design for this study. Chapter 3 discusses the rationale for selecting constructivist grounded theory to guide the design for this study. Chapter 4 illustrates the research process that took place before, during and after the data collection. Ethical considerations, the quality and limitations of the study are also considered.

Chapters 5 to 8 present the findings and analytic discussions of the data through to develop an understanding of how Bruneian nurses perceive the ethical dimension in the ward setting. Chapter 5 examines the category 'nurse at work' which illustrates the first ethical dimension in nursing work. The analysis of the categories 'nurse and doctor' follows in chapter 6, representing the ethical dimension in terms of the expectation underlying in the relationship. Chapter 7 focuses attention on the final dimension, 'nurse and patient'. Chapter 8 discusses the responses in addressing identified dimension, a) 'taking responsibility' and b) 'shifting responsibility to others' which entail a consideration of the elements of conflict and harmony within the ethical reasoning. Chapter 9 integrates the categories developed from the four findings chapters to present the core category 'negotiating ethical responsibility' that explains how Bruneian nurses perceived and responded to ethical issues in practice. The chapter also elaborates the elements of conflict and harmony as a form of reasoning which individual nurses have used to explain their responses to the ethical dimension in practice. Chapter 10 concludes the thesis by summarising and reflecting on the research. This chapter includes the implications of the research findings for nursing practice, education and policy. Recommendations for future research are also offered.

## **1.5 SUMMARY**

The earlier text has analysed the development of nursing in Brunei, which has helped to provide an understanding of the nursing education, particularly the teaching

of ethics. Given the establishment of ethical codes and standards of professional conduct in 2010, this initiative indicates a growing call for nurses in the country to partake of self-reflection on ethical conduct and utilise the documents to inform their ethical decision making and responses. This call however is not entirely embraced by the nursing community, as the ethical dimension in nursing practice is not clearly understood. In response to the positive interest to reach an overall understanding of the ethical dimension in nursing practice, it is necessary to examine how nurses perceive and respond to such a dimension.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

Chapter one presented the political and historical context for understanding the state and composition of nursing in Brunei. Chapter two is focused on the literature pertaining to the theoretical perspectives underlying studies on the ethical discourse in nursing practice. This literature will be followed by a critical review of the empirical studies on nurses' ethical dimensions in nursing.

The relevant literature was reviewed in two stages. The initial review was undertaken when preparing the research, with the purpose of identifying a gap in the existing research and formulating general research questions. A more comprehensive review was conducted towards the end of data collection and data analysis, in order develop theoretical categories with the existing literature.

In section 2.2 there is an explanation of the first stage of literature review procedure and search strategy informed by a grounded theory approach and a summary of the key empirical studies on the subject of 'ethics' and 'nursing'. Section 2.3 described an analysis of the theoretical underpinning of the studies on ethical practice in nursing, which include the meaning of ethics in nursing, the teaching of ethics and the issue of ethical decision making. Section 2.4 presented review analysis of available literatures as I engaged in building theory and leads to explanations for the study findings. Section 2.5 outlines the focus of the research in this thesis.

#### **2.2 FIRST STAGE OF LITERATURE REVIEW**

The initial review was conducted when preparing the research proposal for the first year review board at the University of Edinburgh. The aim of the review was to identify research gaps in the subject pertaining to the study, define general research questions and choose a suitable methodology for exploration of this study. During this



stage, I reviewed the general theoretical perspectives underpinning existing studies on ethical concerns in health care, followed by a critical analysis of the relevant available research in the nursing literature concerning ethical problems. Charmaz (2006) believes reviewing the literature with critical mind will help to identify gaps in extant works, place the research in context, refine, extend or revise existing theories, and to “weave the discussion” in the light of earlier works. This essential preparation is necessary to “frame the problem in the introduction to a study” (Creswell, 1994, p. 23), whilst at the same time allowed me to be general in the literature reading, as well as being informed about the literature surrounding ethical discussion in health care practice as a whole. Nevertheless the specific ethical problems or concerns in the early stages of the research proposal remains elusive. With this ambiguity, I began to develop the ability to question and recognise my underlying assumptions. Whilst Chenitz (1986, p.44) advises that such ability is critical as the researcher to develop “a cautious and sceptical attitude about the literature throughout the study”, the constructivist approach which this study considers, presents an interpretive understanding, in which it recognises the subjectivities in the data analysis, which are built based on reflection (Charmaz, 2009).

In this study, I began reading the broader meaning of ethics in health care practice (Fairbairn and Mead, 1993; Raines, 2000; Fry and Duffy, 2001; Corley et al., 2005; Ulrich et al., 2007). The reason behind that decision was that ethical issues or dilemmas are potentially perceived differently and therefore background data of different context might be useful. Then, two keywords “ethical distress” and “moral distress” appeared on the databases whereby vast literature on moral distress was found. This led to a wider reading on these areas (for example, Holm, 1997 that discussed on the ethical reasoning of health care ; Smith and Forster, 2000 that described on management of medical mistakes). Further reading of theoretical and philosophical work from allied ethics journal (for example, Roth, 1972 that deliberated the contingencies of the moral evaluation; McKee et al., 1999 that examined quality of hospital care) and teaching

aspect of ethics and moral development (for example, Weber, 1992; Krawczyk, 1997; Gorgulu, RS & Dinc, 2002). All these provide a platform to wider understanding of the topic. In grounded theory, it is essential that one read a wider literature and to go beyond the subject which will be helpful in the data analysis and theory construction.

Whilst McGhee et al. (2007) recommended that researchers are to avoid a detailed initial review of the topic literature prior to starting data collection, this is entirely not true. When Glaser and Strauss (1967) first introduced grounded theory, they clearly maintained against reading about the area under study before the beginning of data collection, and even during later stages of the research, they however differ on how, and how much, a literature review conducted in early stages of the research which may possibly 'contaminate' the research product, and thus, deter the emergence of a grounded theory. Strauss and Corbin (1990) challenged Glaser's position whereby they encouraged the appropriate use of literature at throughout the study, discerning the difference between an empty head and an open mind (Strauss & Corbin, 1990; Kelle, 2005). They further argued that the researcher's previous experience and exposure to the subject, as well as a wide variety of literature may (and should) be employed in appropriate phases of the research, from conception to conclusion (Strauss & Corbin, 1990; Charmaz, 2006). This is consistent with the post-positivist philosophy which admits that the researcher inevitably influences the research. Strauss and Corbin (1990) maintained that a prior and on-going consultation with appropriate literature prompts multiple benefits such as: it exposes gaps in the academic literature; it can be employed as a secondary source of data; it can inspire questions; it can guide theoretical sampling and it provides an insight into existing theories and philosophical frameworks. Charmaz (2006) on the other hand advised on a balanced approach of utilising literature during focused coding and this is consistent with the co-construction of meaning which explained by looking at the theoretical literature to achieve a data analysis that goes beyond description and is theorised.

Meanwhile Charmaz (2006) notes the various routes researchers take in terms of the timeline of literature review including whether it is necessary to defer it until the completion of the grounded theory analysis. Attending to the significance of flexibility, Charmaz appears to leave the decision of the timeline to the researcher. In accordance with this, the literature review in this study was routed in two phases, where the first phase took place during the preparation of writing research proposal whereby it help sets the scene. Charmaz (2001) suggested that prior knowledge could be a basis of sensitising concepts that enable researcher to engage analytically with the collected data. Charmaz and Mitchell (1996) elucidate the researcher involvement in the reflexivity process, where there is a need to prioritise the data collected over reviewed literatures, the researcher's own assumptions, prior knowledge, subjectivity and life experiences. In other words, there is a need for the researcher to not disregard existing knowledge, but to critically engage with it from the research outset (Thornberg, 2012). In engaging with literature reading at this stage enabled me to examine and reflect the personal assumption, values, stereotypes and biases through reflexive interpretation, therefore allow the knowledge generated is rigorous and grounded in nature. The consideration in recognising the research context throughout the research process and the interaction with the participants can highly benefit in the co-construction of knowledge (Russell and Kelly, 2002).

### **2.2.1 Literature sources**

The sources for the literature review were identified through the electronic databases: CINAHL, MEDLINE and SEARCHER of the University of Edinburgh. These journal collections became the key resources for the literature search, where research and practice are discussed and new works are presented. Grey literature, such as conference proceedings and reports produced by government departments, was also obtained through government websites such as the one belonging to Brunei's Ministry of Health. Internet searches, such as via Google Scholar, were also undertaken. I also

searched books from the university's library catalogues on the subject where books summarise key theories and specialised texts in a clear and comprehensive way.

The constructivist approach assumes that people, including the researchers, construct the realities they share, therefore, a constructivist study starts with an experience and questions about how participants constructed their reality; thereby, both researcher and participant interpret the meanings and actions from this experience. For example, when the participants discussed on the communication between doctors and nurses, I reviewed the medical sociology literature on professional ethics (Freidson, 1994) which helped to further understanding of the sociocultural influences on professional practice, and to gain some insights into the historical influences that had shaped the health professions. This illustrates how the first level of co-construction was through the communication with the participants and the researchers open coding; this was followed by the use of theoretical literature to go beyond description and towards theorising.

I also sought non-nursing literature such as medical ethics journal and social issues journal to have baseline understanding of the ethical dimension in nursing practice, particularly on the ethical discussion surrounding the patient and the family health care decision. Nonetheless, the nursing literatures on administration and management were also pursued to further understand the nurses' working nature, and how this may possibly influence the nurses' moral responsibility. The reading about nurses' approaches to ethical concern revealed a new emphasis on the development of moral responsibility amongst nurses and the literature was integrated into separate chapters that presented the context of the research. For example, the readings about the nursing work and ward environment became a chapter on the ethical discussion of nurses at work; data about the working relationship and doctor's role were written up in a chapter on the ethical discussion of nurse and doctor; and literature on patient and family interest were reviewed after data was analysed and presented in another chapter

on ethical discussion of nurse and patient. This illuminates well that the literature became “a valuable and essential source of information” (Chenitz, 1986; p.43) even though the focus of the review changed as the main concern was clarified.

On the other hand, in the attempts to provide information about the context within which the participants and the relevant organisation functions and factors that might influence the researcher and participants’ interpretation of ethical dimension in practice, several measures were taken. For example, a visit to the National Achieve of Brunei Darussalam was made to obtain historical and administrative information (through newspaper, magazines) on the healthcare system and nursing state in Brunei. The national newspaper websites such as Media Permata, Borneo Bulletin and Brunei Times were also searched and this has contributed to an analysis of additional data. The non-existent or dearth of written policy in nursing practice lead to the employment of newspaper articles within the thesis where the reports describe the existing agenda pertaining to nursing in Brunei.

At the same time, to understand further on some of the contextual issues, the national and international literature about “nurse’s ethical dilemma” was examined to clarify the common meanings of dilemma. Literature reading revealed that ethical dilemmas were not unprecedented in nursing, rather it involves other multidisciplinary team member, particularly doctors, who were affected to some degree or not. This lead to question of whether the topic itself may need to be refined to explore healthcare ethical dilemma in today’s professional practice. Hence, with the literature reading at this stage, it was then integrated into new interpretations of ethical dimension in nursing practice whereby the research findings within the related literature were further compared with the theoretical concepts and categories developed from this study.

This review of related literature was considered an important, iterative process which was conducted quite an early stage but revised and refined as the research

progresses. This is in contrast to the original stance of the founders of grounded theory, Glaser (1992, 1998, 2005) who repeatedly emphasised the risk of prior knowledge at the early stages of research. Strauss and Corbin (1998), Charmaz (2006) and Bryant and Charmaz (2007), assert Glaser's view is flawed, pointing out the fact that the researcher may have already been exposed to a mass of literature and extant theories related to the problem.

Meanwhile I also reviewed the literature on grounded theory methodology and method, for example on the philosophical perspectives and the paradigm of inquiry (Annells, 1997) and literature on evolving methods (Schreiber, 2001). This reading helped to inform on how grounded theory methodology had the potential to explain what was actually happening in practical life, particularly when there were so many different perspectives in the literature on ethical perspectives in the health care practice. Therefore, the grounded theory method was ideal, as it created a systematic prospect to encourage participants to explain and discuss their main concern and how they continuously resolved that. Charmaz (2006) wrote that it is probable that the prior reading may possibly guide the researcher to select the research interest and develop the study design accordingly. Hence, all these are likely to provide a general sense of direction.

### **2.2.2 Topic and search terms**

Two broad subject areas were searched: ethical problems and nursing. The keywords and terms referring to these subjects were used: 'ethical problems'; 'ethical issues'; 'nursing'; 'healthcare'; 'ethics'; 'ethical decision-making'; and 'ethical distress'.

### **2.2.3 Search criteria**

The inclusion criteria applied to the literature review were:

- Journal articles with full text
- Published in English language
- Accessible digital dissertations and theses
- Web sites of relevant organisations

## **2.3 SUMMARY OF THE PREVIOUS STUDIES ON THE SUBJECT OF NURSING AND ETHICS**

There has been an increasing amount of literature relating to nursing ethics in the past two decades, testifies to the growth of interest in this area, as well as the complexity of decision-making in contemporary nursing ethics. Previous studies in the 1980s, which have provided some significant insights, drew attention to the difficulties experienced by hospital nurses acting as moral agents (Yarling and McElmurry, 1986; Bishop and Scudder, 1990). Whilst the health policy documents may suggest that nurses are able to resolve these problems or the dilemmas they encounter because they know what needs to be done, they have the freedom to do it, and are prepared to shoulder the responsibility for their actions; unfortunately none of this may be true (Nolan and Markert, 2002).

### **2.3.1 Ethics in nursing**

When researchers ask nurses to identify moral and ethical decisions they are required to make in everyday practice, nurses most commonly provide a list of bioethical issues such as abortion, euthanasia, switching off life support, or whether to inform terminally ill patients of their diagnosis (Fairbairn and Mead, 1993). Nurses also continue to report that ethical dilemmas with patients and their families in the areas of end-of-life care, advanced directives, informed consent and withdrawing or withholding treatment constitute moral distress for them in the workplace (Raines, 2000; Fry and Duffy, 2001; Corley et al., 2005; Ulrich et al., 2007). Similar challenges created by these ethical issues have also been reported in the international nursing literature as well (Wagner and Ronen, 1996; Han and Ahn, 2000).

For Schrock (1995), 'medical tendencies' in nursing create barriers for the development of nursing action. Ebright et al. (2003) found that nursing judgments made during actual work, are driven by more than textbook knowledge; they are influenced by knowledge of the unit and routine workflow, as well as by specific patient details

that help nurses prioritise their tasks. Although it is fully within the realm of nursing practice to be concerned with bioethical issues, it may well be that the ethics literature does not satisfactorily reflect the common concerns of practising nurses. Perhaps the question posed by Fry and Duffy (2001) about the full scope and frequency of ethical issues experienced by nurses in current practice, which remain unknown, is not so imperative, when compared to the need to find out in-depth how nurses actually perceive ethical problems in nursing terms, taking into account the contextual factors. Curtin (1980) and Muyskens (1982) could be partially right when they contended that the system within which nurses work, may prevent them from acting in a morally autonomous fashion when dealing with ethical dilemmas. Further, previous studies have provided insights into the process of acquiring ethical reasoning; nevertheless, far more work is needed to assist all nurses to become confident, ethically sensitive practitioners (Nolan and Markert, 2002).

The literature search revealed that nursing is often considered to have an ethical dimension (Nortvedt, 2001; Gastmans, 2002; Scott, 2006), especially with the changes in health care and society (Coverston and Rogers, 2000). Similarly, with the technological and medical advances, the growing complexity of care situations and the lack of evidence-based interventions which require nurses constantly and critically to reflect on how they can contribute to their patients' wellbeing (Spitzer, 1998; Coverston and Rogers, 2000; Gastmans, 2002). Subsequently, nurses have an essential duty of care to protect the wellbeing of patients, and not to take advantage of their vulnerability (Thompson et al., 2006). This conclusion implies a certain kind of moral responsibility demanded by the patients who put their trust in nurses (Holm, 1997). Unfortunately, studies have shown that this demand can be problematic to meet (Georges and Grypdonck, 2002; Niven and Scott, 2003; Varcoe et al., 2004; Torjuul and Sorlie, 2006).



### **2.3.2 The teaching of ethics**

Many nursing graduates appear to lack the knowledge, skills and confidence to be ethically sensitive practitioners (Weber, 1992) and such personal deficits can subsequently limit their effectiveness in terms of providing quality nursing care. Woods (2005) described this perception as a nagging feeling that insufficient numbers of nurses are emerging from their undergraduate or postgraduate education with an appropriate ethical awareness of their individual or collective moral capacity. This perceived shortcoming raises questions as to whether these courses actually prepare nurses to respond effectively to the demands of the modern healthcare system. Is it possible that this phenomenon could be associated with a number of persistent ideas in nursing; for instance, that nurses are still obliged to follow the ‘moral lead’ of the medical profession (Peter et al., 2004a)? To answer this question, back in 1989 Levine claimed that nurses have lost sight of the essence of nursing ethics: the relationship between nurse and patient. It appears that the weight on bioethical predicaments, and what may be an obsession with ‘ethical dilemmas’, tends to obscure the ordinary everyday ethical actions nurses engage in, by responding to another human being in distress. These rather simple acts, such as making a person comfortable, providing them with information, accepting their informed healthcare decisions, providing respect and dignity in interactions, and just listening carefully to what a patient has to say, form the moral foundation of nursing practice.

Meanwhile a number of teaching strategies, such as ethical decision-making models, were introduced to support nurses in dealing with the ethical challenges that they encounter on a daily basis of their practice. As a result, many studies (e.g. Frisch 1987; Duckett et al., 1997; Krawczyk, 1997; Dinc and Gorgulu, 2002) were carried out, which indicated that nursing education in general, and education in ethics in particular, have a positive impact on the development of students’ moral development. While this appears encouraging, it is becoming increasingly difficult to ignore the fact that, despite exposure to theories of ethics as a didactic part of nursing education, students

may still struggle with its clinical application (Birkelund, 2000). This perceived disconnection between ethics theory and clinical practice, as reported by nurses, may be the reason why nurses tend to demonstrate inconsistent patterns of ethical decision making (Grundstein-Amado, 1993).

It should be noted that the majority of the studies dealing with students' moral development have focused on teaching strategies in the classroom, while far too little attention has been paid to research focusing on the role of clinical placements. This may mean that the importance of the role of ethics education has not been adequately acknowledged. However, Erdil and Korkmaz (2009) argued that clinical practice is an essential part of nursing education and students require effective clinical placements to integrate theoretical knowledge into practice. Meanwhile Nolan and Markert (2002) point out in their study that the students did not consider their clinical experience to have been particularly significant in their growing ethical and moral understanding. This, of course, is not a surprise, because in a study looking at clinical practice, nurses face moral dilemmas and most are not prepared to make moral judgments (Erlen and Sereika, 1997). Nursing students who learn idealistic nursing ethics may become stressed when dealing with real ethical dilemmas, which may not necessarily reflect what they have learned in theory (Han and Ahn, 2000; Woods, 2005). Meanwhile Gibbons et al. (2008) contended that sources of both distress and eustress (healthy, positive stress) in nursing should be included in their clinical experiences. This view could be explained by four studies which focused on ethical reasoning in Greek, Korean, British and American nursing students (Cameron et al., 2001; Nolan and Markert 2002; Park et al., 2003; Lemonidou et al., 2004) describing their experiences of moral awareness, ethical conflict and professional moral personhood. The researchers concluded that the 'real world' of clinical practice was challenging to ideals, which often contributes to moral distress in nurses (Doane et al., 2004). This distress, however, may be associated with the complex demands of caring for patients and their families (Morrisey and Jensen 1997).

According to Cameron et al. (2001) ethical reasoning is best learned in the practical context, with support and guidance from those more experienced, for nurses to analyse their attitudes and behaviour. It is not by identifying ethical dilemmas that the skills of ethical reasoning are learned, but in resolving them, and it is likely that clinical experience would be extremely influential in this matter. Auvinen et al. (2004) further demonstrated support for this premise when it was shown that students who had gained experience in dealing with moral issues during their clinical internment, were at a higher level of moral reasoning than students without such experiences (Auvinen et al., 2004). Meanwhile, degree students scored significantly lower in ethical decision-making than hospital-based certificate students in a study examining the relationship between ethical decision-making and learning climate (Yung, 1997). Little is known, however about how nurses involve themselves in ethical decision-making and action or about educational processes that support such practice (Doane et al., 2004).

So far the literature has looked into the meaning of ethics in nursing, whereby the results of most studies suggest that students, as well as registered nurses, experience difficulty in carrying out the ethical dimensions of their function. The value and strategies of ethics teaching to the students was also reviewed.

### **2.3.3 Ethical practice in nursing**

Whilst the bioethics and other professional literature continue to reflect concern about persistent unethical care practices, nursing literature has tended to focus on external or contextual barriers to ethical nursing practice within health care systems. For example, institutional policies and procedures, 'the doctor-nurse game', paternalism and hierarchical positions have been identified as having, at least potentially, a powerful effect on decision making and action, and have been long acknowledged as barriers to ethical nursing practice (Stein, 1967; Jameton 1977; Swider et al., 1985; Evans, 1986; Yarling and McElmurray, 1986; Bishop and Scudder, 1987; Adamson and Kenny, 1993; Millette, 1993).

Meanwhile Fagerstrom (2006) described the nurses' situation in terms of a struggle between being and not being a good nurse, and between what one wants to achieve and what is possible to achieve. For Fagerstrom, it is not sufficient for nurses to know simply what is good for patients; they must be able to apply it in practice. This appears to be challenging because the hierarchical medical establishment structure, for example, is consistent with the argument that nurses are not free moral agents in the acute setting (Yarling and McElmurry, 1986). Nurses' lack of autonomy, for example, led them to be caught between the desire to act in support of the wellbeing of patients, being their voice when ethical decisions have to be made, and the desire to be understood and valued by medical colleagues (Uden et al., 1992; Sundin-Huard and Fahy, 1999).

#### **2.3.4 Ethical distress**

When nurses fail to do what they think is right, because of institutional constraints, they experience disequilibrium and painful feelings, which Jameton (1984) called moral distress. These feelings include low self-esteem, frustration, anger, sadness, anxiety, shame, insecurity, heartache, dread, resentment, guilt and depression which any or all, may affect nurses both professionally and personally (Webster and Baylis, 2000).

Studies have found that although hospital nurses know what ethical conduct is in nursing practice, they believe that hierarchical pressures often make it difficult for those nurses to maintain ethical standards (Buckenham and McGrath 1983). The term 'difficulties' is often mentioned when nurses have to implement the ethical dimensions of care in daily professional practice (Woods, 2005). As a result, Holly (1993) described how nurses' perceived inability to act on behalf of their patients resulted in moral distress, frustration, and powerlessness. A perception of powerlessness to influence ethical decision making, is a common experience for hospital nurses (Erlin and Frost, 1991).

If they do take ethical action or advocate on behalf of their patients, they find themselves disliked by other personnel and then find they have to seek covert or subversive ways to promote their own moral survival (Hutchinson, 1993; Astrom et al., 1995;

Lutzen and Schreiber, 1998; Spence, 1998; Sundin-Huard and Fahy, 1999; Woods, 1999; Wurzbach, 1999; Rodney and Varcoe, 2001; Gaudine and Beaton, 2002). Some reported feeling concerned about the ethical dilemmas they face, but they take no action and most of them are uncertain about what action to take (Penticuff and Walden, 2000). They become passive, and as a result of accepting their own powerlessness, they distance themselves from patients and therefore ethical issues are no longer perceived as difficult (van der Arend and van den Hurk, 1995). When patients' rights are not respected, for example, they are no longer perceived as ethically difficult, even though nurses are aware of the violation (Raines, 2000). In this way, nurses endanger their own moral integrity and the burden of the situation may increase (Georges and Grypdonck, 2002). There is also suggestion that many nurses are confused about their ethical role (Davis, 1979). What is more disturbing is when Woods (2005) described how some of those who are newly qualified lack ethical confidence whereby they do not assert themselves in the face of moral conflict. Instead, those new nurses choose to find ways to cope with their own moral distress, often by passive acceptance or compromise, sometimes at the expense of doing what they have been taught is the right thing to do (Kelly, 1998).

### **2.3.5 Moral strength**

A number of authors argue that when one holds up nursing as a moral practice, the concept of moral responsibility entails elucidation (e.g. Fry and Johnstone, 2002; Peter and Liaschenko, 2004). The International Council of Nurses' code of ethics for nurses (International Council of Nurses, 2000), for example, is intended as a framework for ethical standards and a guide to support nurses in their ethical conduct in practice. The code clearly states the ethical responsibilities of nurses. However, Malmsten (1999) strongly contended that this code falls short when dealing with the relational and contextual nature of nursing practice. Malmsten claimed that it is the individual person who acts, not the role, thus it is necessary to reflect on how the responsibilities are realised.

To be able to carry out such responsibility, moral strength has been identified as one key factor that is required. When Lindh et al. (2009) carried out a hermeneutic inquiry that looked into nurses' experiences of moral strength in practice; the nurses described how they risked challenging those in authority, when traditions and habits compromised patients' safety. This action required making choices, careful deliberations and arguments with powerful professionals about the care that should be provided. Such a challenge also required the strength and competence to act from one's own professionalism, grounded in understanding the patients' situation and needs, as well as being able to judge what is in the patients' best interest. The question is, can nurses afford to continuously and tirelessly challenge the authorities? Dierckx de Casterle et al. (1997) advocated that more nurses are aware of the ethical dimension of their daily nursing practice, and of the importance of this dimension in performing good nursing care, but at the same time, there is an understandable concern about the capacity of nurses to put the ethical dimension into practice.

### **2.3.6 The ideology underlying implementation of ethical nursing practice**

Research has consistently shown growing concern about the implementation of ethical nursing practice, particularly with the association of several external and contextual factors that form a barrier. While that could be a partial explanation of the problem, Dierckx de Casterle et al. (2008) were adamant that nurses' ethical practice is not well understood. They argued that promoting ethical practice among nurses requires better understanding of the difficulties they experience when they use ethical values to guide their care decisions, and of the impact these difficulties may have on nurses' practice. While for Van der Arend and Van den Hunk (1995) most of the definitions of a moral problem still lack an empirical basis; hence, it is difficult to assess the extent of such definitions pertaining to the moral problems as experienced by the nurses themselves. At the same time, it is necessary to be careful when associating most ethical decisions with typical everyday life, because what we clearly do not want is for the nurses to become desensitised to the needs of individual patients (Thompson et al., 2006).

## **2.4 SECOND STAGE OF LITERATURE REVIEW**

The second and subsequent phase of literature review took place as I developed the theoretical categories whereby I needed different literature to help in developing the categories and thus explaining the findings.

### **2.4.1 Summary of second review of literature**

The second stage of literature review shown that the ethical concerns that the nurses have encountered in practice, were subjected to various dimensions. In this study, these dimensions were embedded in categories of ‘nurse at work’, ‘nurse and doctor’ and ‘nurse and patient’. In the first category of ‘nurse at work’, the ward environment does not seem to be particularly helpful and supportive for ethical nursing practice, a practice which provides the highest quality ethical care. The stress and tension nurses often feel result in a lack of confidence and ability to address their ‘ethical’ concerns appropriately. Aiken and colleagues (2008) described the negative impact of the clinical practice environment on a nurse’s job satisfaction. They concur that the quality of the practice environment is an ethical issue, because of its important effect on the quality of patient care. Peter and colleagues (2004b) suggest that their practice environment may affect the nurses’ sense of health and well-being in the workplace. In a study by Rodney et al. (2006), nurses express frustration and ethical distress when staff and other resources are scarce, and this deficit has interfered with their ability to provide safe and ethical nursing care.

In the second category of ‘nurse-doctor’ dimension where the participants persistently commented on the conflict they experienced with the doctor pertaining to the role of the doctor in patient care, possibly one reason that nurse-doctor collaboration is not widespread is that nurses and doctors have not been socialised to collaborate with each other and therefore do not believe they are expected to do so (Keenan et al., 1998). Sheard (1980) believes that the occupations clash because nurses and doctors structure work in radically different ways and, though they work side by side, they tend to

misunderstand the methods and inner logic of one another's work. For example, nurses work on a strictly scheduled hourly basis, sense that a scarcity of resources exists, and are assigned work by room or bed. In contrast, doctors work on a course of illness or case basis and sense an abundance of resources. Furthermore, several authors report studies that help to understand doctor-nurse conflict and its resolution. May (1995) states that nurse and doctor education is different and that conflict does not reflect the amount or quality of nursing knowledge. The doctor is trained to make decisions concerning what treatment is best and the nurse is not. The difference in knowledge base can be the principal reason for conflict. In clinical practice, however, as well as in the literature, there is a growing concern about implementing ethical nursing practice. Ethical practice seems most problematic in daily ethical dilemmas, arising from situations that involve conflicting values or beliefs about what is the right or best course of action (Ham, 2004). Only some of the participants were ready or able to confront and challenge the doctor's decision, and such confrontation has to take place in a subtle manner. This was illustrated in Rushing's (1965) interview study which suggests a more subtle process, by which psychiatric nurses attempted to gain influence within an overall framework of admiration behaviour. Where nurses felt that doctors' instructions were not in the best interests of patients, they attempted to exert influence through the use of 'power strategies'. This strategy allowed the nurses to demonstrate an expression of unease, but was a method, which avoided any open disagreement with the doctor. Therefore, as an alternative approach, nurses might gently mention the matter to ward chiefs and let them take it up with the doctor involved.

In the third category of 'nurse-patient' dimension where both nurse and doctor appear to trust the family to make decisions, doctors remain to be perceived as playing a major role in influencing such decisions. The "patient's body" is often the justification used by some nurses when it comes to information disclosure, whereby there is a need for patients to know what is going on. According to Seeberg and colleagues (2004), the Western perception of the patient as a rational, self-conscious creature, capable



of making his or her own decisions on treatment avenues offered, is insufficient and inappropriate; therefore it must be replaced with a perception of the patient based on 'Eastern' values. An example given is the Confucian philosophy where 'individuals are never recognised as separate entities; they are always regarded as part of a network, each with a specific role in relation to others'. One important implication of the Confucian perception of personhood is that the family, rather than the individual patient, is seen as the primary negotiation partner for the doctor, in the doctor-patient relationship. Seeberg et al. (2004) suggest that there is a possibility that doctors tend not to burden the patient with poor prognosis, and instead, they argue that it is far more sensible to involve the family in such a sensitive situation. Similarly McMullan (2006) explains that there has been a shift in the role of the patient, from passive recipient to active consumer of health information. McMullan describes that the health professional can respond to the increasing use of the Internet by health consumer in ways such becoming defensive, and asserting their expert opinion as a result of feeling threatened. Another choice would be for both patient and health professional to collaborate in analysing the Internet information. In a quantitative study by Barnoy and colleagues (2009) on the Israeli hospital nurses' attitudes towards the informed patient, most nurses held positive attitudes towards patients with Internet information; in particular, nurses with prior experience had more positive attitudes towards informed patients than nurses with no such experience. It was suggested that there is a need to prepare nurses to be ready for encounters with such patients.

Meanwhile end-of-life decisions were the most common topic raised by participants. There is evidence that supporting family involvement with the dying person is an important aspect of end-of-life care, for both patient and family (Andershed, 2006). Furthermore, the satisfaction of the patient's family depends on how the family experiences communication and support from the healthcare team (Lowey, 2008). Baggs and Schmitt (2000) concluded in a review of the literature of end-of-life decisions that few studies such as Emmauel (1995) and Asch et al. (1997) have looked

at the role of nurses in this process. It is uncertain whether nurses initiate, participate or have any input into such decisions. It has been observed that the distinctions in professional values between nurses and doctors are related to the dying process (Oberle and Hughes, 2001), thus leading to conflict and ambiguity in the clinical setting. There is still uncertainty whether there is consensus between doctors and nurses once the end-of-life decision is made.

The three ethical dimensions constructed in this study suggest the identification of ethical concerns in nursing practice suggests that the ethical sensitivity or awareness of nurses and the nursing profession. Rest (1986) offered a four-component model of moral development which describes steps in the process of attaining moral and ethical maturity. He suggests that one's development of ethical skill begins with an awareness of the impact of a situation upon others (sensitivity). With this awareness, one then decides that there is a need for action and chooses a course of action (judgment). One then makes a commitment, consistent with one's own values and beliefs, to take action (motivation). Finally, one figures out the best course of action for this situation and persists to implement it (action). Without sensitivity to the feelings and reactions of others, ethical actions do not develop.

In employing the categories of 'getting help' and 'raising concern' as a form of strategy, these are often perceived as the right thing to do as a professional. At the same time, there is also a need to protect patients from harm; a need that has been subtly and clearly cited by the nurses. Kelly (2006) reported that a study of intensive care nurses revealed that they tended to use avoidance in order to protect relationships and prevent open arguments. Organisational constraints and lack of authority appear to hinder the nurses from addressing their concerns accordingly. This results in them shifting the responsibility to others, such as ward managers, medical doctors and the patient's family. This act of shifting responsibility to others is seen as necessary, since it does not create any further conflicts. Dierckx Casterle et al. (2008) conducted a meta-analysis

of nurses' responses to ethical dilemmas in their work. They examined nine studies on nurses' ethical reasoning and implementation of their ethical judgment in response to ethical dilemmas in nursing practice. The results showed that nurses tended to reason in a conformist way regarding daily ethical dilemmas, being guided by conventional workplace rules and norms, rather than using creative and critical reflection. The research group also found that nurses have difficulties implementing ethical decisions in more challenging contexts. Furthermore, nurses' conformist patterns of ethical response in daily ethical dilemmas seem to be a universal phenomenon.

Another factor that appear to influence nurses' responses to ethical concerns is the need to maintain good relationships with workplace colleagues, which many viewed as leading to group harmony. The need for sense of belonging allow the individual to feel acknowledged and connected with a group or team, and which will eventually facilitate group cohesion (Levett-Jones and Lathlean, 2008). Therefore the act of shifting responsibility to others is viewed as something over which they have no control due to a lack of authority, and at times, the people is often seen, or sees themselves, as not ready to take responsibility for the consequences of their proactive actions. Sekerka and Bagozzi (2007, p. 132) noted that nurses' practice with moral courage when they confront situations that pose a direct threat to care, which may endanger the patient's safety and wellbeing; therefore the nursing response was argued to be based upon a commitment to serve and advocate for patients and the profession. Whilst such harmony is appreciated, there is a clear division between hierarchies of nurses, in how nursing team communication was delivered and managed; the hierarchies with the doctors are complex. The challenges of intra-professional relationships are not unique to nursing. Fieldwork studies on peer relationships in, for example, medicine (Friedson 1975; Bosk 1979; Cassell 1991) have generally found a reluctance on the part of professionals to confront, challenge, or discipline each other. In DeMarco's (1998) review of some studies on "constructive confrontation" among nurses, she reported that nurses perceived an ethical dilemma in these situations, in which commitments

to maintaining relationships conflicted with commitments to truth-telling. Previous reports have suggested that staff nurses tend to avoid conflict with peers, however, and particularly to avoid discussions of errors and problems (Siu et al., 2008; Roberts et al., 2009; Mahon and Nicotera, 2011). Explanations for this avoidance have tended to concentrate on psychological and cultural reasons (Valentine, 2001; Brinkert, 2010; Mahon and Nicotera, 2011).

To further understand this state, Kohlberg's theory of moral development (1958) provides a useful framework for understanding how one's personal ability to make moral judgments is influenced over time by personal development, knowledge acquisition, experience, and the environment (Ketefian and Ormond, 1988; Cohen and Erickson, 2006). Individuals at the highest level of moral development are said to be using their conscience to determine the right course of action by independently examining and delineating moral values and principles rather than by relying on group norms (Ketefian and Ormond, 1988).

Whilst all these strategies lead to the attempt to negotiate ethical responsibility in facing the concerns that the nurses encounter, but at the same time they also believed that the lack of assertiveness and contribution from the ward manager may lead to a huge discrepancy in the image and status of nurses in general. Follett (1977) was one of the first to study organisation-based conflict, suggesting that conflict be viewed as differences of opinions and differences of interest. Follett noted that conflict is neither "good" nor "bad," and that it should be used to identify the sources of differences. Greenfield (1999) noted that nursing leaders (managers) may not be receptive to establishing collaborative relationships with doctors, because this may be seen as reinforcing the subservient role. He recommended that nurses and doctors receive training that recognises the unique contributions of each, in providing quality patient care. Leadership support and education are key elements to improving relationships between individuals with different worldviews (Follett, 1977). Nonetheless, the nurses

know that there is a right thing to do, but feel that in some circumstances, the system they are in does not allow them to act. It is worth pondering the point that inaction in some areas of practice is seen as both acceptable and appropriate in most cases. This could possibly be a form of moral distress, as theorised by Jameton (1984), whereby nurses who know the right thing to do, but cannot pursue the right course of action because of institutional constraints.

#### **2.4.2 The research focus**

So far the literature has looked into ethical practice in nursing whereby the nurses appear to be aware of the ethical dimension of their daily nursing practice; however, such a dimension remains ambiguous. This situation results in moral distress amongst the nurses, which is linked to concerns about their capacity to put the ethical dimension into practice. A number of literature sources focused on the concept of moral strength, which only offers a partial explanation of the moral responsibility that is placed on nurses.

This thesis therefore extends the existing studies on nursing and ethical practice in order to explore the ways in which nurses in Brunei understand the ethical dimension of nursing in practice. The broader research questions that to be answered are formulated as followed:

- (1) What is the most difficult situation you are involved with, in the ward setting?
- (2) How do you respond to that situation?
- (3) What are the reasons for your responses?

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter deliberates and illustrates the methodological journey that I went through to answer the research questions. The aim of this chapter is to describe the choice of qualitative research design and grounded theory for this study. In the discussion of grounded theory, the variety of grounded theory families is examined and the basis for selecting constructivist grounded theory as a method of enquiry is justified. The reflexivity of my position in the research is also discussed.

#### **3.2 QUALITATIVE RESEARCH DESIGN**

Qualitative research is an umbrella term which refers to investigations that attempt to broaden or deepen our understanding of how things came to be the way they are in our social world. There are many different approaches to doing qualitative research such as ethnography, grounded theory and phenomenology. The methodological approaches are described in terms of the type of analysis they imply, with different epistemological approaches involving different sets of assumptions about what sorts of knowledge are important.

The choice of qualitative method over quantitative method rests upon the flexibility that the former offers. This degree of flexibility reflects the kind of understanding of the problem that is being pursued. Unlike quantitative research, the strength of the design in the qualitative approach is the naturalness and adaptation of the interaction between the researcher and the participants through open-ended questions. This allow the participants to freely respond, in their own words, rather than forcing them to choose from fixed responses, as quantitative research designs can do. Open-ended questions have the ability to evoke responses that are meaningful and culturally salient

to the participant, rich and explanatory in nature (that is to ask ‘why?’ and ‘how?’), and not simply to elicit a straight ‘yes’ or ‘no’ response.

Qualitative research is also effective in identifying less tangible factors, such as social norms, socioeconomic status, gender roles, ethnicity, and religion, whose roles in the research issue may not be readily apparent. Furthermore the idea of qualitative research is not to gather numbers, but to explore and describe how nurses perceive and feel about ethical problems in practice. Therefore, qualitative techniques such as in-depth interviews, focus groups and observations would allow the exploration of how people experience a given research issue. Whilst a survey questionnaire may be possible to describe this study, a series of in-depth interviews is needed to establish insights into the private, often contradictory and complex beliefs and understandings that people hold.

Most importantly qualitative methods are ideal for exploring topics where little is known; making sense of complex situations, gaining new insights into phenomena, constructing themes to explain those phenomena, and ultimately fostering a deep understanding of the phenomena (Morse and Richards, 2002). Additionally, the application of qualitative research methods, and a grounded theory approach in particular, has enabled the exploration of the subsidiary, implied questions within the study, as to why, how, where, when, under what conditions, and with what consequences the phenomenon unfolds (Wilson, 1995).

While there are commonalities, qualitative research incorporates a range of methods with different ontological and epistemological underpinnings, perspectives and purpose. Given the focus and type of the research problem that the current study aimed to address, the development of an explanatory theory from the views of the study participants was the primary objective of this research. Therefore, after evaluations of the different qualitative approaches, such as phenomenology which aims to provide a descriptive study of how individuals experience a phenomenon; ethnography that

focuses on the discovery and description of the culture of a group of people; case study that seeks present the detailed account and analysis of one or more cases; it was identified that grounded theory was the best-fit methodology to achieve the objective of this study and explore nurses perceptions of ethical concerns whilst the direction of individual in-depth interview was guided by the GT processes of theoretical sampling, theoretical sensitivity, memo-writing and theoretical saturation. This critical qualitative research was also appropriate for this study as this approach enables further understanding of the ethical practice in Brunei as it ensures the research is grounded in the specific meanings, traditions, customs and community relations within the Bruneian community. A detailed explanation for choosing a grounded theory approach is presented in the subsequent section.

### **3.3 INTERVIEWING NURSES**

With the aim of the study to explore the ethical concerns in nursing practice, the views of general nurses in medical and surgical ward settings in Bruneian hospitals were sought. The general nurses' experiences of their practice provides greater insight and understanding of how ethical problems present themselves, and how these were responded. Recruitment of participants did not present a major challenge in this study since there are more than four medical and surgical wards in the main hospital, demonstrating the anticipated number of potential participants. Other factors included the support by ward managers on the ward; staff turnover; and that medical surgical settings are considered less complex and hectic which is in contrast to intensive care units or emergency departments.

The approach taken in this study is one of interviewing individuals as opposed to groups. The individual interviews allows me to explore deeply into the social and personal views and how the participants perceive ethical problems, whereas the group interviews will only allow a wider range of perceptions, thus prevents delving deeply into the individual perceptions (Rubin and Rubin, 2005). This A number of approaches



were employed which then lead to the co-construction of meaning with interviewees by reconstructing perceptions of events and experiences related to health care delivery (DiCicco-Bloom and Crabtree, 2006).

As mentioned earlier, constructivist grounded theory is rooted in pragmatism and relativist epistemology, whereby the data and theories are not discovered, but are constructed as a result of my interactions with the study's participants. The co-construction of meaning in this study was influenced by my perspectives, values, privileges, positions and interactions. Therefore to begin the co-construction, I needed to become 'theory sensitive' which indicates an awareness of, or insight into, the subtleties of the meaning of data. The sources of my theoretical sensitivity include the previous readings on ethical practice and ethical dilemma in hospital settings.

At the same time, my personal and professional experience as a former practicing nurse and nurse teacher provide me with an insight and understanding of how things work in the clinical setting, as well as why, and what will happen under certain conditions. As an example, the experience of having cared for hospital patients made me sensitive to what stress in the workplace means in the health care context. The meaning of a stressful work environment in the hospital wards is relatively different in each ward. However, in a conceptual sense there are both similarities and differences between the meanings of stress in the workplace of hospital ward settings. Drawing upon these experiences has helped me to be aware of my own theoretical knowledge and assumptions, as well of pre-existing research theories. At the same time, I remained open-minded and data sensitive and therefore avoided the trap of trying to force non-fitting pre-existing codes into my analysis.

The co-construction of meaning also took place during the analytic process, whereby the interaction of the data occurred as I was collecting data and asking questions about it, making comparisons, things about what I saw and heard, making postulations, and developing small theoretical frameworks about concepts and their relationships. This

iterative process directed me to look closely at the data, to give meaning to words that seemed previously not to have meaning, and to look for possible explanations of what was happening. All these points allowed me to develop an increasing sensitivity to concepts, their meanings and relationships.

### **3.4 GROUNDED THEORY**

#### **3.4.1 Versions of grounded theory**

Before I describe the versions of GT, it is central to understand the context of the earlier version of GT. In 1960, Anselm Strauss joined the School of Nursing at the University of California, San Francisco. In 1961, at the age of 33 years, Barney Glaser had completed his PhD at Columbia University in New York. At this time, Strauss managed to secure a grant for a four year funded study to examine the experience of dying by terminal ill patients in hospitals and he recruited Glaser to the research team. Six year after that, once the study had been completed, they then published the concept of GT. They both believed in (1) the need to get out in the field if one wished to understand what is going on; (2) the importance of grounded theory in studying reality; (3) the continually evolving nature of experience in the field for the subjects and the researchers; (4) the active role of persons in shaping the worlds they live in through the process of symbolic interaction; (5) continuous change and process and the variability and complexity of life; and (6) the interrelationship between subjects' meanings and their action (Glaser 1992, p. 16). They also made the argument that discovery of theory from data was possible, easily accessible and understandable and empirically relevant. Likewise, Suddaby (2006) wrote that Glaser and Strauss were annoyed by what they perceived as a lack of respect for qualitative methods by the extreme positivism that had flooded most social research. They were concerned that this movement was a bid to discredit qualitative research as unsystematic or merely exploratory.

The idea of generating new theory from data, as opposed to testing existing theory, made that idea, combined with GT as a research design, interesting to other social

scientists. This made GT gradually become more widespread. For the next 10 years, both Strauss and Glaser taught together at the University of California. Strauss continued teaching there until 1987, while Glaser left the academy to write, publish, consult and teach around the world, as he is still doing. Over the years, both of them appear to have had dissimilar intellectual discussions about the use of GT methods. Strauss and another author, Juliet Corbin, a professor of nursing, published a text called *Basics of Qualitative Research: GT Procedures and Techniques* in 1990 (Strauss and Corbin, 1990). Glaser however refuted this offering with a book called *Basics of GT Analysis* in 1992, which generated a debate amongst grounded theory scholars. Despite their differences, Glaser and Strauss remained friends on both personal and professional levels, until Strauss' death in 1996.

In total, there are presently different versions of GT, namely the traditional or classic GT; then an evolved Straussian version; the constructive GT, which was made famous by Kathy Charmaz who focused on the place of the researcher in the text, and their relationship with the research participants. In selecting the different approaches of grounded theory, Annells (1997) suggested that grounded theory can be conducted within any paradigmatic position, provided this can be thoroughly justified when planning and reporting the study. Methodologically, there are no right or wrong approaches to grounded theory methods; however, there are differences that need to be taken into account.

The theory version that this study considered was constructivist grounded theory (Charmaz, 1995, 2000, 2006). Charmaz viewed grounded theory methods as “a set of principles and practices, not as prescriptions or packages” and emphasised “flexible guidelines, not methodological rules, recipes and requirements” (Charmaz, 2006, p. 11). I was drawn by Charmaz's social constructivist perspective, which “emphasizes diverse local worlds, multiple realities and the complexities of particular worlds, views and actions” (Creswell, 2007, p.65). Charmaz (2006) and Allen (2010) emphasise that

data is constructed through an on-going interaction between researcher and participant and this approach assumes that data and theories are neither emergent nor discovered but rather are constructed by both the researcher and the research participant: the researched.

In constructivist grounded theory, the researcher employs a reflexive stance and studies how, and sometimes why, participants construct meanings and actions in specific contexts (Charmaz, 2006). In my view, this flexible approach, which recognises that interaction between the researcher and the participants is necessary in order to understand the meaning of the experiences shared during the research process (Charmaz, 2000; Lincoln & Guba, 1985). The constructivist approach also best suited to my research question which explores the complexities of ethical and professional nursing issues, the abstract nature of the concept and the meanings the participants assign to these issues which are framed within the context of their own lives. Focusing on the data and the possibilities for meaning that can be constructed from them, I went beyond the surface in seeking meaning in the data, searching for and questioning tacit meanings about values, beliefs, and ideologies. Furthermore, Charmaz (2004) postulates that the intimacy of intensive interviewing used in this study provides a deeper view of the interviewee's life. In qualitative research, such an approach allows me to enter the world of the participant, to discover what is important from the viewpoints of the people responding and what things really mean to them.

Furthermore the choice of the grounded theory methodology for the study was decided by the research question, together with the consideration of the applicability and feasibility of the method in the context of the phenomena of interest. Charmaz (2006, p. 3) adding that while other qualitative traditions permit investigators to treat data as they please, without clear directions on how to proceed, grounded theory provides "explicit guidelines" that direct researchers about how to carry out their research. For many pragmatic researchers like myself, grounded theory is very useful in answering

their questions, enlightening their thinking and for providing them with reassurance, when hesitations arise during the research process.

The research questions i) “What is the most difficult situation you are involved in the ward setting?” ii) “How do you respond to that situation?” and iii) “What are the reasons for your responses?” do not easily fit into the positivist paradigm that aims to test existing theories, to investigate cause–effect relationships, to predict and to control, and to place emphasis on measurement and explanation (Munhall and Boyd, 1993).

The goal of this study was to develop a substantive theory which can help people better understand and interpret the processes through which nurses see ethical dimensions in their daily work. To achieve this, in line with constructivist grounded theory, the development of inductive reasoning and bottom-up theory alone approach, are not sufficient to inform the theory generation process, and hence the need for abductive reasoning. The concept of abduction is typically traced to Peirce (1929) who argued that abduction was the mode of reasoning that allowed for creative inferences and the discovery of new knowledge, while both inductive and deductive modes of analysis relied on developing and refining existing knowledge (Reichertz, 2007). Constructivist grounded theory adopted this mode of reasoning as a vital component to allow infused creativity to be introduced into the research process (Charmaz, 2006).

This study adopts the definition of abductive reasoning provided by Charmaz (2006, p. 188):

*Abductive reasoning is a type of reasoning that begins by examining data and after scrutiny of these data, entertains all possible explanations for the observed data, and then forms hypotheses to confirm or disconfirm until the researcher arrives at the most plausible interpretation of the observed data.*

Based on this definition, it can be seen that abduction provides the means for the development of new concepts that may act as higher levels of phenomena in explaining

possible patterns in the data. Charmaz (2009, p.137) positions abduction as secondary to induction where:

*Grounded theory begins with inductive analyses of data but moves beyond induction to create an imaginative interpretation of studied life. We adopt abductive logic when we engage in imaginative thinking about intriguing findings and then return to the field to check our conjectures.*

According to this perspective, abduction reflects the process of creative inferencing and double-checking those inferences with more data. Timmermans and Tavory (2012), on the other hand, argue for a much more crucial rethinking of the relationship between data and theory construction. For them, rather than thinking about abduction as a point of supposition within a broader inductive framework, they propose an analytical approach that privileges abduction. This means that, in the process of theory construction, abduction comes first. For them, whilst grounded theory still offers useful tools for the organisation of qualitative research, it is only in relation to abduction that theory construction becomes meaningful; a move which will then foster theoretical innovation. They further argue that through abductive analysis, the process requires an essential rethinking of core ideas associated with grounded theory; specifically the role of existing theories in qualitative data analysis and the relationship between methodology and theory generation. They also accentuate the ability to recognise a finding as surprising, in light of existing theories, and presume in-depth familiarity with a broad range of theories.

In the context of this study, two elements were followed to address the abductive reasoning. Firstly, theory matching was used at various instances in the theory construction process to make sense of various developed relationships among concepts, and to articulate the findings in a manner consistent with other existing theories. Secondly, propositions were derived from the integration of co-constructed theory with information from the existing literature. The creative nature of abductive reasoning facilitated the generation of a rich offering of theoretical concepts and relationships.

Meanwhile, at the outset of selecting the appropriate research design, the “intuitive appeal” of grounded theory, as described by Myers (2009, p. 111), for new researchers influenced my decision. Such appeal suggests the researcher can get deeply “immersed” in the data, and this immersion is translated practically in the constant comparison, coding and memoing approaches to data analysis. Charmaz (2006, p. 2) reinforced this notion and asserts that grounded theory provides novice researchers with the needed principles and “heuristic devices” to “get started, stay involved, and finish your project”.

The final appeal in undertaking a grounded theory approach is the opportunity it offers to explore and examine a problem area that is under-explored (Strauss and Corbin, 1998). As I undertaken the process of shaping the research question through examination of the literature, it became clear that only a few studies had explored the problem of what is really perceived as ethical problems in the daily working lives of nurses. It is therefore particularly appropriate to this study, as little is known about this research inquiry’s topic in the existing literature, as suggested in chapter two.

### **3.4.2 Principles and practices in grounded theory**

As stated earlier, there are different versions in doing grounded theory. Although there is a variety of detailed guidelines outlining the use of grounded theory, conducting a grounded theory study is ‘learning by doing’ and hence process learning (Schreiber, 2001). Doing GT, in this context, either involves following set guidelines (e.g. Strauss and Corbin 1998) or viewing grounded theory methods as principles and practices that are used in generating the end product (Charmaz 2006). It is the latter position that was adopted for this study.

#### **3.4.2.1 Sensitising concepts**

Sensitizing concepts are terms, phrases, labels, and constructs that call for analysis into what they mean to people in the settings being studied (Patton 2015). The term “sensitising concepts” was coined by Blumer (1954, p. 7) who advocated using

sensitizing concepts as a guide to fieldwork with special attention to the words and meanings that are prevalent among the people being studied. Social researchers are incline to view sensitizing concepts as interpretive devices and as a starting point for a qualitative study (Padgett, 2004), whilst Charmaz (2003, p. 259) has referred to sensitizing concepts as “those background ideas that inform the overall research problem”.

In the context of this study, having read the broad literatures around ethical concerns and ethical practice in health care context, there were a number of sensitising concepts which was loosely defined such as ethical dilemma, ethical conflict and ethical distress. This has provided me with some initial direction to this study as I examined into how these concepts are given meaning in a particular place or set of circumstances being studied (Schwandt, 2001). In recognising sensitising concepts, it allowed these terms or concepts to be further examined in the context of the participants, and the variations in meaning and the implications of these variations. Moreover, being aware and reflecting on one’s assumptions allowed me to ask specific kinds of questions about the phenomenon of interest (Charmaz, 2006).

#### **3.4.2.2 Theoretical sensitivity**

When Glaser and Strauss (1967, p.1) developed grounded theory, they clearly sought the “discovery of theory from data” where it was central to grounded theory that researchers were led by data rather than by predetermined hypotheses. Glaser argued that the process of theoretical sensitivity was necessary to ensure that theory would naturally emerge from data. However in constructivist approach, the process of theoretical sensitivity works relatively different, and this related to the epistemological differences. For a constructivist grounded theory, there are multiple realities that is co-constructed by the researcher and participants. Therefore in reporting and discussing my findings, I encountered predicaments whilst trying to ensure that my interpretation of data was not confused with the perception of reality. I interpreted and processed



those communicated perceptions through my own filters of experience and background knowledge.

In a constructivist approach, the process of theoretical sensitivity works relatively differently from other version of grounded theory, in this case relating to epistemological differences. For constructivist grounded theory, there are multiple realities that are co-constructed by the researcher and research participants. Therefore, in reporting and discussing my findings I encountered predicaments whilst trying to ensure that my interpretation of data was not confused with the perception of reality. I interpreted and processed those communicated perceptions through my own filters of experience and background knowledge.

The process of becoming theoretically sensitive took place both before my analysis of any data as well as during the analysis of data. With my experience as a former nurse and nurse teacher, my theoretical sensitivity is linked closely to the literature that I have reviewed, which enables me to become sensitive to concepts, meanings and relationships. That sensitivity also helps me to see the research situation and its associated data in new ways, and to explore the data's potential for developing theory. This active role of employing knowledge, understanding and creative skills is central to fostering the generation of concepts and relationships from the data being analysed (Bryant, 2002). As mentioned earlier, the creative strategy of abductive reasoning would facilitate the development of rich and creatively articulated theories (Reichertz, 2007).

Throughout the process of co-construction of meaning, I also periodically stepped back to ask: "What is going on here?" For example, whilst I was doing the fieldwork, it quickly became evident from the participants' accounts that the nurses choose to remain relatively quiet submissive in managing conflicts with medical doctors or nurse colleagues. This was seen as necessary, so that whenever possible the nurses avoided creating bad relationships with work colleagues. Furthermore, it was mentioned that

when conflicts arose, they did so over different events; some of which were related to patient safety and others were related to administrative related concerns. One would anticipate that the nurses' responses would vary according to the perceived gravity of their concerns; the more serious the concern, the more likely the nurses would be to act. It is assumed that verifying this proposition would simply be common sense, yet I established that sometimes the hypotheses were frustratingly relatively incorrect. It was learnt that there was no need to force this proposition upon the data, because I was categorising the severity of the ethical concerns according to my own perception of the situation. This, as it turned out, was not necessarily the participant's perception. In other words, I used my own perception of 'harm' to judge the gravity of the concerns, but the nurses did not necessarily think the same as I did. For example, when a doctor decided to not tell the truth to a patient, it was perceived as acceptable, and not harming the patient at all.

With this act of going back to the data, questioning them and asking why particular statements and actions did not seem to fit my perceptions, I was able to recognise and understand that the nurses acted on the basis of their own perceptions, particularly those relating to the significance of the situation. Such perceptions were not necessarily the same as those of other health professionals. Thus I found that by regularly engaging in a general question of asking "what is going on with the data", I was helped to refine the focus of the ongoing study.

At the same time, as I compared and co-constructed the data, I regarded these explanations of meanings as provisional. For example, the ethical issues and explanations experienced by nurse managers in Malaysia (Musa et al., 2011) were considered provisional until supported by actual data. In other words, categories that are derived from the research literature are always context specific, which means that they do not necessarily apply to my study. Therefore, in the first category of this study, 'nurse at work', for example, the comparison of data has created an awareness of existing literature and theories on understaffing. This knowledge helped to inform

the development of subsequent categories, such as ‘nurse and doctor’, and therefore inform my analysis, rather than direct it. I was however careful not to try to force these categories to fit the literature; therefore, I avoided using the existing categories to create other new categories.

Along with simultaneous data collection and data analysis, writing memos was also a helpful method to become theoretically sensitive whereby I reflected on the co-construction of themes whilst contrasting them with background knowledge in an attempt to guard against the data being distorted as a result of researcher induced bias (Schreiber, 2001). Not only that, the constant comparative method compelled me to re-examine previously coded data in the light of the co-construction of themes which were then followed up in subsequent interviews.

As mentioned earlier, there is a strong emphasis to read wider reviews of literature in the theory construction process in order to make sense of various developing relationships among concepts. For example, when research participants described the negative perception of nurses amongst the general public, I tried to link it to literature. I found many studies of nursing have shown that nursing care of the body is considered ‘dirty’ and is consequently devalued by the general public. I then reviewed socialisation theory to make sense of various relationships amongst the developing concepts and related these relationships with other existing theories, such as Goffman’s theory of stigma (1969).

#### **3.4.2.3 Theoretical sampling**

Theoretical sampling is described by Glaser and Strauss (1967, p.45) as:

The process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. This process of data collection is controlled by the emerging theory.

In grounded theory, sampling is one of the key aspects that determine the quality of the generated theory. Sufficient theoretical sampling is important for the development

of a diverse and wide range of theories, while scanty theoretical sampling can lead the theory development process towards a weak, thin and non-cohesive base of theory (Glaser and Strauss, 1967). The importance of theoretical sampling is further elaborated by Charmaz (2003, 2006) who suggested that theoretical sampling plays a central role in obtaining relevant data that is important to the process of theory development. Theoretical sampling plays an essential role in refining the process of theory development, together with the theory itself, by leading the researcher towards relevant data. It is this data collection process that remains until and unless new data stop emerging.

Sampling is also essential in grounded theory because of the presence of research bias. Bias exists in and across all research designs, and it is often challenging, perhaps impossible, to eradicate. Bias ensues at each stage of the research process and not only that, bias impacts on the validity and reliability of study findings and misinterpretation of data; bias can therefore have important consequences for practice. In this study, I practiced selection bias which is the process of recruiting participants based on the study's inclusion criteria. It was essential to recruit participants that met my research questions. At the outset of my research, I recruited participants with a range of experiences in relation to the topic being explored. Recruiting nurses from just one particular medical ward possibly led to bias towards nurses in other medical settings.

Charmaz (2006) postulates that initial sampling helps in determining where to start data collection. The sampling also tends to be general and open, and becomes focused as the theory develops (Charmaz, 2002). This initial data also informed the generation of a range of categories, which are illustrated as the 'building blocks of theory' (Strauss and Corbin, 1990, p. 102), thereby guiding my further data collection. In this study, purposive sampling was initially employed to collect and analysed data because there were no data from participants to direct what further information should be sought and explored. The purposive sampling was followed by the use of theoretical sampling

which facilitated me to determine who to sample next and secondly, what questions to ask during interviews. In this study, following the initial sample of nine nurses, subsequent participants were selected based on the information which develops from the data already coded. This process provides a means of ensuring that new data contribute to theory development and that they work with the accumulated concepts and categories through a measure of fit and relevance (Glaser, 1978).

The theoretical sampling began when I recruited assistant nurses and nurse managers in order to inform my developing understanding of the nurses' scope of practice. As focused codes were identified, I recruited senior nurses who hold administrative roles, in an attempt to understand the nursing roles and responsibilities, particularly the concern about nurses as professionals. Because my aim was to understand the process of such a concern and the strategies they took to respond to that concern, I needed to understand further how implementation of the strategies may pose a challenge for these nurses. With this informed theoretical considerations, I recruited participants from the field of nursing administration, such as from the Nursing Board of Brunei, Department of Nursing Services and Quality and Safety Unit, where they can provide further clarification of the difficulties experience by nurses in practice. By sampling nurses from both practising and administrative areas, I aimed to examine the broader reach of the co-construction theory and to complete inductive development of key concepts.

Meanwhile interview guides (see Appendix B) were not rigidly observed; rather the guides were reviewed throughout data collection and data analysis. Four general questions were asked to all participants: i) how do you describe your job as a nurse? ii) what is the most difficult situation you are involved with in the ward setting? iii) how do you (normally) respond to that situation? and iv) what are the reasons for your responses?

Through the course of this research, specific interview questions were then developed based on analysis from earlier interviews and following themes that were addressed, in order to reflect the developing theoretical focus of a study (Schreiber, 2001). For example, following the seventh interview, I asked about the support that is available for nurses after clinical incidents. Then, following the ninth interview, I asked an open-ended question as to what patient consent means to the participant; this question was expanded to explore: “do participants perceive family autonomy as acceptable?”, and “what is the participant’s opinion towards the communication between patient and nurses?” In addition to these themes, participants mentioned points regarding nurses’ professional image, as well as the hierarchical structure and current management of nursing.

The interview questions changed and improved over time, influenced by codes and categories developed from previous interviews. For example the question “Have you ever heard of conflicts in your ward?” was changed to “What do you know about conflicts of care?” A question mentioning factors viewed as ‘continuing professional development’ was removed after the first interview phase. The reason for this was that initial interview findings indicated that participants did not perceive this area as related to their ethical concerns.

Meanwhile participants spoke about ‘patient care’ and the challenges encountered whilst caring for their patients. This aspect of care appeared to be a potentially imperative explanation for the strategies approaches by the nurses. I then modified the interview schedule again to include questions about the idea of dealing with patient and family when either one or both parties were perceived as relatively critical of the care being provided. It appeared that nurses’ construction of the meaning of ‘difficult patient and family’, as revealed during interviews, also prompted me to recruit charge nurses in the busy medical wards. The interview questions were constantly revised as a result of the analysis of the participants’ data.

In my analysis of data, I had learned that 'nursing image' and 'nursing authority support' both had a range of meanings. I also learned that having local doctors and younger nurse manager had been central to the process of responding to the nurses' ethical concerns. For this reason, I added new questions for the subsequent interviews to directly explore the meaning of 'support' and 'good relationship' and how nurses view these aspects in their practice. I also learned more about the barriers nurses encountered during the process of dealing with their ethical concerns. I reflected on the nurses' understanding in adopting other alternative strategies when dealing with complex concerns or issues and I further clarified the concept of 'courage in practice'.

Through careful selection of participants and modification of the questions asked during the data collection, I was able to clarify uncertainties, reflect on my interpretations, and build my developed theory. This exploratory of ideas of co-construction of themes in subsequent interviews were also based on previously gained insights, allowing me to either filled gaps in data or abandoned codes altogether. In total, twenty-eight participants were recruited who were largely representatives of hospital nurses in the three participating hospitals. The sample included nurses with at least three years of work experience, and who held varied posts such as staff nurse, assistant nurse, nursing officer and hospital matron.

#### **3.4.2.4 Data collection**

Data collection in grounded theory is one aspect that is evidently exhaustive in the literature. Glaser (1998) asserts that grounded theory is a method that can be used with any kind of data (qualitative and quantitative), the range of data collection methods used which includes observations, interviewing, videos, and questionnaires or gathering information in records and reports (e.g. Glaser and Strauss 1967, Locke 2001, McCann and Clark 2003). For Charmaz (2006), the depth and richness of gathered data is far more important, and that the goal is to collect sufficient data that fit the task rather than ensuing prescriptive guidelines.

The constructivist perspective advocated by Charmaz (2006) emphasises that discovered reality arises from the interactive process between researcher and participant. Thus, in this study, interviewing provided the type of stimulating, interactive and creative environment necessary for interaction with the participants, in order to understand the meaning of the experiences shared in the interview process. I asked four general questions to guide the in-depth interviews: “i) how do you describe your job as a nurse? ii) what is the most difficult situation you are involved with in the ward setting? iii) how do you respond to that situation? and iv) what are the reasons for your responses?” These questions were designed to stimulate a conversation with the participant and thus create a more relaxed and spontaneous atmosphere, hence facilitating discussion of the questions.

Individual in-depth interview was considered as the most appropriate form of data collection for several reasons. First, the probable “sensitive” issues such as patient’s death that the participants shared during the interview, which is emotion laden or inspire feelings of dread or awe (Farberow, 1963). Whilst the connotation of a “sensitive” research topic is dependent on both context and cultural norms and values, Lee (1993) postulates that there are three issues that create a concern a sensitivity, namely issues that are considered as private, stressful, or sacred, such as sexuality or death; issues that if revealed might cause stigmatisation or fear; in this study, failure to rescue patient may disclose negligence or poor practice of the nurses; and issues that are related to the presence of a political risk where researchers may study areas subject to polemic or social conflict. In this study, whilst the sensitive nature of the research was considered at the beginning of the study, it was not that apparent. For example, although “unethical practice” is considered by many to be happening, not many are willing to open about it openly. Lee (1993, p.4) suggests that sensitive research:

*Poses a substantial threat to those who are or have been involved.*



Support for this view was provided when some of the participants requested the information they had revealed be kept confidential ('off the record'), and that where they felt the stories or events to be 'sensitive', they began to lower their voice. In the recruitment process, there were some potential participants who highlighted concerns about the safeguarding of their anonymity. I explained to them that whilst I intended to always maintain the participant confidentiality and anonymity, I advised them to reflect and speak about this 'sensitive' information with a friend; for example, as a form of debriefing. As I reflected on the quality of the relationships that emerged between myself and the participants, I observed the researcher's obligation to carry out authentic and reflexive analysis and reporting that integrates participants' voices in ways that were respectful and reflexive of their desires concerning their involvements in this study.

Secondly, Charmaz (2006) asserts that intensive interviewing permits an in-depth exploration of a particular topic and goes beneath the surface of ordinary conversation. In engaging a semi-structured interviews, it enabled me to explore and examine a complex behaviour or decision-making processes as posit by Agar and McDonald (1995). They hypothesise that individual interviews enable the participants to explain themselves and that this results in the sharing of elaborate and sometimes intimate information.

Throughout my journey in the interview fieldwork, I learned the differences between participants, such as the level of experiences and academic qualifications, which impact the data in terms of their ability to give and take from each other, and their ability to discuss the complexity of the area of interest being explored. This part of the research also led me to a better understanding of myself and awareness of the power structure within which I was situated. In particular I learned to negotiate this power structure to try and complete the fieldwork. For example, when I interviewed participants who possessed power and authority, there were times when they appeared

to disregard some of the issues raised by the nurse participants; for example, on understaffing and its impact on patient care. Further, I noticed a tendency to indict the nurses for not being able to prioritise their work. At this point, an understanding of two issues about myself became clearer: me as an integral part of the research process who was a data collection tool, and how I was positioned within the research field; both were important aspects of the study. An important part of understanding myself as a research tool lay in identifying the links between the ontological and epistemological positioning and the methods I chose to employ in the collection of data. I also made it a point to explain my role as a researcher. An awareness of myself as the researcher and my interpretation of seeing and being in the world are reflected in the research design. Nevertheless, my being a former nurse, and currently a nurse teacher, has somehow influenced the interviews.

Undertaking constructivist research emphasised the researcher's relationship of reciprocity with the participants. Therefore, in order to establish a less hierarchical relationship between me and the participants, I adopted several strategies. For example: a) I scheduled all interviews at a time and location chosen by the participants; b) I also used a relatively flexible approach to questioning, hence allowing participants to assume more power over the direction of the conversation; c) at times I also shared my understanding of the key issues; d) I also maintained an open stance towards the participants, sharing personal work experiences and answering questions asked both during the interview and afterwards. To position myself as the participants' partner in the research process, rather than taking on the role of an objective researcher, is essential to developing a constructivist grounded theory design. This then required a critical reflection upon my underlying assumptions, as well as heightening my awareness of listening to participants' stories as openly as possible.

I also adopted a flexible approach to the moderation of each interview session by allowing the discussion to flow and take its own course, even if that meant that the

participants did not necessarily address my principal questions in the right order or that the conversation went ‘off topic’. To further enhance greater depths in mutual meaning making during interviews, I engaged with the participants through my readiness to try to understand a participant’s response in the context of the interview as a whole.

Meanwhile, before I ended each interview, I would use the opportunity to ask participants to clarify concepts in the process of refining those concepts, thus forming part of theoretical sampling. Once completed, interviews were then digitally recorded and transcribed by me. I wrote memos as soon as each interview was over, and throughout the fieldwork. I then took a month for data analysis in which coding and memo writing occurred. Then, during a second phase of data collection, I completed nineteen further interviews, again with memo-writing during the data collection period.

#### **3.4.2.5 Analysis of data**

The first steps in the analysis of data were transcribing, translating and managing the qualitative research data. Whilst coding, the process of organising and sorting qualitative data, is considered the second crucial step in data analysis, coding and data analysis are not synonymous. Deliberations were put forward to suggest that coding does not replace data analysis per se, particularly relating to aspects of creativity. Atkinson (2013), for example, maintains that there has been deficient thought and consideration given to the nature and generation of ideas in data analysis. He stressed that productive ideas are not born of inspiration or actions of data sorting; rather they stem from multiple interactions with the field of interest. Atkinson (2013, p.57) further mentions that “basic ideas which are very good descriptions of creativity in any kind of social research, have been turned into a series of formulae and procedures which are more likely to be deadening, rather than creative”. He acknowledges that coding can be a valuable way of organising one’s thoughts and particularly useful when sharing a data set among a research team, but it has very little to do with the real work of creative analysis.

In this study, I engaged in simultaneous data collection and analysis, whereby I started analysing data from the beginning of the data collection. The interviews were audio taped and transcribed by myself, the transcriptions being a verbatim account of the interviews. I considered this transcribing component is an important requirement into the research analysis, however I realised that there would be no time available to transcribe comprehensively and begin the process of analysing the data at the end of each interview.

In an attempt to address this important issue, I followed Charmaz's advice (Charmaz, 2006) who suggested a flexible approach whereby I started recording initial reflection comments in a research journal, making notes on discussed topics and the similarities and differences between the respondents' accounts. As much as possible, I attempted to personally transcribe at the end of each data collection stage, checked my efforts against the audiotapes for accuracy and then analysed the gathered information. It was also important that I analysed and reviewed the key points as soon as possible after each round of interviews. This allowed the process of theoretical sampling to occur.

At the same time, memos were written throughout this exercise to keep track of thoughts and ideas regarding the data analysis. Writing the memos right after each interview, while being in the field, allowed me to capture initial ideas and make comparisons between participants' accounts. These memos also assisted me to make comparisons among my reflections, which enriched the data analysis and guided further data collection.

The first set of interview transcripts was coded with the help of the qualitative analysis software NVivo, which however did not prove to be the most helpful. This difficulty persuaded me to turn to Microsoft Word to make the coding. Following the grounded theory guidance on coding, I worked through each of the transcripts and used line-by-line coding to note down themes and phenomena in the margins. Some codes were very close to the participant's account and others more abstract or conceptual. Keywords

and phrases were then identified and written on differently coloured 'Post-it' notes. These were then arranged in a logical order on the large paper sheet.

As more and more interviews were coded, this sheet started looking less like a random collection of labelled 'Post-it' notes but more like a mind-mapping exercise or a tree where branches of thought grew from certain categories. This 'Post-it' data was later transferred to a purchased mobile application called iMindMap. This system of creating codes, combined with reflection, was maintained for coding all interviews. At the end of this coding exercise, the large paper sheet was covered with colourful 'Post-it' notes containing categories and codes. The codes were modified by being applied to further interview transcripts; subsequently the codes were entered into the Microsoft Word table to allow searching the interviews, re-sorting of material and consistent redefining of codes, in order to support the analysis process.

I started the process of analysing the data by generating inductively as many ideas as possible from early data via general reading, followed by a review of the literature to establish existing theories on the data. I also took notes in the form of memos, to record my impressions and insights, which helped me in the later stages of analysis.

The list of codes helped me to identify the issues contained in the data set, where the codes were combined and linked to one another, as at this stage they are more abstract as compared to the initial codes. I then identified themes and patterns from the data via the reading, comparing and contrasting process. Thus, through these coding strategies and the memos written during the analysis phases, I was able to identify concepts and categories as well as subsequently co-constructing the core category.

#### **3.4.2.6 Coding and categorising data**

Coding is an essential step in grounded theory data analysis. As Charmaz (2006, p.43) defines it "coding is the process of labelling a line, sentence or paragraph of interview transcripts or any other piece of data with a short and precise name." I noticed that

during coding, I generated the bones of analysis which were then integrated and assembled at the stage of theoretical coding. Charmaz (2007, p.45) described this as “crucial for identifying emergent themes for further analysis and subsequent theory development.”

### **Initial Coding**

At the end of each data collection stage the transcripts were coded line by line, a process described by Corbin & Strauss (2008, p. 160) as “fracturing the data”, in order to examine the words used by the participants to describe their world view. This view was informed by their experiences and the feelings, meanings and assumptions they attached to those experiences. Line-by-line active coding kept me close to the data, thereby preserving the fluidity of the participant’s experience and gave me new ways of looking at that revelation. It allowed me to enjoy a complete immersion in the data, which in turn provided an insider’s view.

Throughout the initial coding process I moved quickly through the data and constantly compared data with data. In doing so I was careful to apply what Henwood & Pidgeon (2003, p.138) described as “theoretical agnosticism” to the process by adopting an open, agnostic and critical stance towards the data and not the participants. I highlighted words and excerpts of interest to me and assigned initial short gerund codes to these excerpts. Charmaz (2006) advocates the use of gerunds (using verbs as nouns) to build a sense of action into the coding from the start of the coding process.

After several interviews, I generated a total of 600 initial codes that were assigned to a single sentence or word from the transcripts. Many different actions and processes such as ‘image’, ‘angry’, ‘lack of support’, ‘verbal order’, ‘finishing the job’ and ‘understaffing’, were identified and coded. I then merged the codes that captured how nurses illustrate their perceptions of ethical concerns. By comparing codes against codes and data against data, I also merged the responses that nurses took when faced with the incidents creating those ethical concerns. For example, the codes ‘angry’,

‘shouted at’, ‘unfair’, ‘being ignored’, and ‘patience’ from the initial codes were re-coded as ‘being professional’ and thus helped to define the participants’ wish to be treated as professionals. After the classification and categorisation of data codes, the codes were later assembled into twenty six abstract concepts (see Appendix F).

### **Focused Coding**

In focused coding, I pursued a selected set of central codes throughout the entire dataset and the study. This requires decisions about which initial codes are most prevalent or important, and which contribute most to the analysis. Through focused coding I examined all the words used by the participants to describe their worldview and their experiences, as well as the feelings, meanings and assumptions they attach to those experiences. The most frequent and significant codes were selected and then raised to tentative categories. This process involves memo writing which, according to Charmaz (2006, p.72), is the crucial step between data collection and the draft because “it prompts you to analyse your data and codes early in the research process”. Once the focused codes for each individual interview transcript had been established, I began to write early memos to myself about each focused code. I adopted an informal free-writing style in jotting down whatever thoughts came to mind about the focused code, in an attempt to tackle the question “what’s happening here in the data?” This process uncovered the tentative categories and provided the focus for further data collection, in the form of theoretical sampling that continued until all the properties of the categories were saturated.

I also identified repeated ideas in the Initial Codes and classified and merged these codes into categories in the Focused Coding. For example, I grouped codes such as ‘trust issue’ and ‘nurse’s poor image’ to capture the nurses’ perceptions of ‘difficulties in practice’. Because these perceptions seemed central to their practice, and because they were talked about often, I decided that ‘working relationship’ should become a focused code. By comparing codes against codes and data against data, I distinguished the

category of 'working relationship' from other focused codes, such as 'communication', and I understood the relationship between them. An example of how the interview data is coded into Initial Coding, and then to Focused Coding, is shown in Appendix F.

### **Theoretical Coding**

Whilst Focused Coding facilitates the organisation of the codes and concepts, established during the Open Coding stage, into higher level categories, Theoretical Coding enables the saturation of the core categories identified during Focused Coding. Theoretical Coding is not the final stage of coding; rather it helps to connect the core category and related categories to create a storyline. In this study, theoretical codes were co-constructed from the data as I analysed the data via coding and memo writing. Along with these principles, the interplay between collecting data, theoretical sampling and theoretical sensitivity influences the development of theoretical coding.

In the subsequent interviews, data generated entailed me to revise earlier codes because a topic emerged that was too implicit in earlier data, may possibly be overlooked but gained importance in later interviews (Charmaz 2006).

The process of creating theoretical categories began with the process of breaking data down into much smaller components, labelling those components and then comparing data with data, case with case, event with event, code with code, to understand and explain variation in the data. Codes were eventually combined and related to one another and at this stage they are more abstract than at the pre-combination stage, and are therefore referred to as categories or concepts.

Meanwhile all of the memos which I had written through processes of abstraction and reflection, along with the major categories that had emerged, were printed out; I then cut them up and scattered them on the dinner table. These print-outs were compared and assessed to ensure that my theoretical development was associated with the data and that there were no areas where my interpretation of categories could not be easily traced back to the data. This exercise of physically printing the memos and categories,



and arranging them accordingly, was very helpful in ensuring that categories linked together meaningfully.

According to Glaser (1978, 2005) the theoretical codes assisted in the recognition of patterns and in the process of theorising what was actually happening during the process of identifying ethical responses towards the ethical dimension in nursing practice. The various factors prompting the nurses' ethical responses were consolidated into four groups: i) rapport that nurses have, ii) experience of the nurse, iii) internal courage of the nurses and iv) perception of authority. The influence of each factor on the manner nurses' respond to their ethical concerns was identified. The use of theoretical coding worked to ensure consistency and objectivity in the process of my analysis of the nurses' responses (Glaser, 1978).

In this coding phase, I continued seeking new categories of evidence and examined these three categories, 'nurse at work', 'nurse and doctor' and 'nurse and patient' which provided me with analytical criteria for the development of conceptual relationships between categories and their relevance to the literature (Glaser, 1992; 2005; Glaser & Kaplan, 1996). As the coding procedure before this phase worked to fracture the data and cluster them according to abstract similarity, theoretical coding along with sorting weaves the fractured pieces back together again. This reuniting conceptualises causal relationships between the hypotheses derived through Initial and Focused Coding. The use of memos and constant comparison between focused codes is instrumental for theoretical coding. During each of these refining and saturation processes, the analysis moves from mere description to conceptualisation. In this study, the analyses resulted in the co-construction of six refined categories: 'nurse at work', 'nurse and doctor', 'nurse and patient', 'taking responsibility', 'shifting responsibility' and 'conflict-harmony paradigm'.

The terms or concepts associated with each conceptual category were not necessarily identical to those mentioned by all participants; nonetheless iterative conceptualisation

indicated that these refined categories incorporate within them the underlying concerns of participants in the study. The worked example of coding is presented in Appendix D.

Thus, as I organised and developed conceptualisations and explanations about the categories, I also contextualised my findings, incorporating a wider picture in which they made sense. The findings were also compared to existing theories and other findings discussed in the relevant and extant literature. All this helped me to become more theoretically sensitive. This analytic process of constant comparison and ongoing questioning of the data, leads to the identification of a core category “negotiating ethical responsibility” which explains and establishes links between categories and categories to codes.

#### **3.4.2.7 Memo writing**

In the grounded theory method, memo writing is an important step in the conceptualisation of data. Before I entered the fieldwork, I began writing memos about the research topic where I started to note my preconceptions and continued to do so after each interview. This habit allowed me to reflect and learn about my own assumptions every time the participant talked about the same topic, and hence heightened my awareness of the topic. Memos also serve the researcher as analytical tools (Charmaz, 2006); helping the researcher to pause and reflect on the data collection procedure and on the data collected. They also provide insights and are also helpful in deliberating on why a certain participant holds a particular point of view.

To be able to allow concepts to emerge, and to identify the core categories, a memo writing technique informed by constructivist grounded theory was adopted, starting from the early stages of the research endeavour. In this study, three distinct types of memos were employed: i) project journal, ii) descriptive, and iii) analytical memos. This resulted in the writing of over 60 memos capturing the conceptual and methodological

development of my theory. These memos ranged in length from a few lines to several pages.

Project journal memos are used for detailing the research process. These memos were kept as part of my personal notes, which I shared and discussed with my academic supervisors in order that they were kept informed about the research process. For example, in one of the memos, I wrote about one participant who did not wish to elaborate on his role as a nurse and yet insisted that nursing is a stressful job. The memo helped me to understand my interview technique and I used this understanding to record my thinking about the research area and how it might influence my analysis of data.

In addition to project journal memos, descriptive and analytical memos were also implemented. Descriptive memos are mere descriptions of interview transcripts, while analytical memos go one step further, and are employed for conceptualising the responses of participants into theoretical concepts. Analytical memos enabled me to reflect upon participants' responses, as early as the draft stage, and very often through informal writing. The various memos developed through time were thus compared and integrated. Below are offered two examples of my memo writing:

Memo 12: Sharing view with doctors (December 19, 2011)

*Participants spoke about the necessity to keep quiet when they encountered ethical concerns. An example given is safe admission of a patient. They expressed concern that some patients are simply not "fit" to be in a general ward. For them, these patients require intensive monitoring. When asked why they don't share their view with doctors, they replied, nurses don't decide who can and cannot be admitted. It is the doctors' decision. That's the way it is. We just have to accept the decision. (Field Interview 4)*

Memo 15: Nurse-doctor relationship (January 3, 2012)

*Participants spoke about the decisions that doctor's make which they believed are not within the patient's best interests. They said, they don't want to argue with doctors, as it is not good for the relationship. To them, not saying anything is best for everyone. According to them, they will only speak up if the decisions really harm the patients. (Field Interview 7)*

Re-reading these field memos, I noted the codes ‘doctor’s decision’ and ‘that’s the way it is’ were so relevant for the nurses to sustain a good relationship with the doctors and colleagues; thus emphasis was placed on maintaining ward harmony. I also reflected that whilst ‘not saying anything’ was not necessarily equivalent to being passive, it suggested that nurses have acquired a set of strategies and responses whereby to them, disagreements with medical colleagues were not advisable. Hence, knowing of the need for abstraction in the conceptualisation of theory, I tried to find meaning in the data that goes deeper than the surface, and Charmaz (2006) advocates that we use ‘action codes’, in order to keep our coding closer to the participants’ experiences.

Memo-writing has also provided me with an opportunity to remember, question, analyse and make meaning of the data that was generated. Through memo-writing and reflective process, I acknowledged personal influences in the co-construction of meaning. As a co-constructor of meanings, my background and other factors exert multiple influences on the way I interpreted the participant’s account during the interview and this fact needed to be made transparent within the memo. For example, I wrote:

Memo 20: Priority of needs (April 6, 2012)

*I just had three interviews with staff nurses who talked about their relationship with doctors. While they know their coming to work is solely for the patients and to meet the patient’s health needs, but it seem that as time goes along, the nurses appear to be lost and swamped with the other needs coming from the work itself, from the doctors, their superiors and other health professionals. It then became a point where they are in the state of confusion as to whose needs should be met. This juggling confusion really put these nurses at a disadvantage! I’ve been a nurse before, and it actually is true. The ward can be too busy and too stressful. (Field Interview 11)*

Reflecting on this field note, I noted the many references to confusion of priority of care; in particular, the connection between a patient’s needs and the nurse’s own needs. This then led to nurses being in a state of confusion as the clashes of needs somehow put nurses at risk of not addressing certain needs. For example, some of them claim to having had to spend a lot of their time doing non-nursing care (technical care) and less

time on actual patient care. I kept writing the memos about what I encountered in each interview, addressing both my preconceptions and what I learnt from the interviews. This helped me to stay focused on what interested me the most.

*Memo 7: Nurse's autonomy (December 18, 2012)*

The nurses said that Bruneian nurses need to be vocal. Not all the time though. It all depends on the situation and consequences that is. Is this simply a question of nurses' autonomy, like the western nurses where they seem vocal in expressing their own opinion? (Field Interview 5)

Reflecting on this field note, I recorded my thinking about how and when nurse's (a nurse's or nurses') autonomy occurred, how they changed, and what the consequences were if the nurses decided to emphasis this concept.

*Memo 25: Educated nurse (May 13, 2012)*

*A number of participants spoke about the importance of "further studies" amongst nurses. They believe that only when nurses are highly educated, like medical doctors, will they be able to on the same par as doctors. They will be able to question and challenge the doctor's decision and actions if it deemed not safe for patients and everyone else. Is this really the answer? What could be other motives for responding to ethical concerns? (Field Interview 21)*

In the above memo, I made comparisons between codes in order to find similarities and differences and raised questions to be answered in subsequent interviews. At the end of the data collection and analysis, I had developed provisional ethical dimensions experience by the nurses and their strategies to respond.

As data began to accumulate into categories, I began to reflect on what was developing and this process of reflection was greatly enhanced through the use of memos. As the number of my categories grew, through constant comparison and constant reflection, the memos started to become rich and reflective. At the same time, I also questioned what the participants were telling me. I observed certain inconsistencies and discrepancies and noted when they were more, or less, passionate in their narratives. For example, the third participant I spoke to was recalling one critical incident involving medication error. When she spoke about the incident, she became relatively upset about 'how' and

‘what’ the nurse manager did to overcome this error from occurring again. In particular the respondent emphasised how she felt that the lack of stern action and inadequate sense of responsibility from the nurse manager was compromising the patient’s safety. This higher level of concern in her narration was noted and included in all associated codes and categories. This later became an important symbolisation in terms of this nurse’s perception of responsibility, which was observed in other nurses when they related to experiencing similar situations.

#### **3.4.2.8 The core category**

In traditional grounded theory, the concept of a core category is essential to the development of the substantive theory. Without a core category a study cannot be characterised as informed by grounded theory; it is not a grounded theory study (Murphy et al., 1998). For traditional grounded theorists, the dichotomy between emergence and construction continues in the identification of the core category. For Glaser (1978, p. 95) “it always happens that a category will emerge from among many and ‘core out’ of its own accord”.

Charmaz (2006) on the other hand, does not insist on only one core category. Constructivist grounded theory assumes the relativism of multiple social realities (Charmaz, 2003, 2006). As a result, whilst classic grounded theory seeks to identify and conceptualise one main concern and its repeated resolution, constructivist grounded theory presents a more diffuse theoretical product which does not centre upon a core category (Martin, 2006). This is intended to allow for the multiple truths perceived within constructivist research, and the emphasis on capturing multiple participant perspectives, rather than looking for one point of view.

Charmaz’s (1990, 2000, 2006) posits that researchers robustly create the story line, which does not merely emerge from the data but is grounded in them. Within a constructivist approach, the core category is established through a dialogue between researcher and data. In other words, constructivist grounded theorists recognise their

input and the fact that they define what is happening in the data (Charmaz 2002). They do not claim to have discovered the one real meaning but simply an interpretation of one's own understanding and participants' representation of theirs.

In this study, the core category "negotiating ethical responsibility" had been abstracted from various categories to form one core. All of the participants who had been interviewed to this point had expressed concerns which related to this core concept and the concepts which were grouped into this category. It is this degree of saturation, in both breadth and depth which led to its selection.

#### **3.4.2.9 Theoretical saturation**

Qualitative researchers generally seek to reach 'saturation' in their studies. Often this is interpreted as meaning that new data does not add new information. Theoretical sampling (as mentioned earlier) and theoretical saturation are two important processes of constructivist grounded theory. Theoretical saturation is considered to have been achieved when the core categories that have emerged from the research process are saturated or developed with sufficient data, to the extent that the incorporation of new data provides no new information or supplementary insights.

Charmaz (2006) proposes that saturation is the stage at which the core categories, identified during the analysis, are supported through relevant and rigorous data and thus the various properties of the categories are established in great detail. This is a subtly different form of saturation, in which all of the concepts in the substantive theory being developed are well understood and can be substantiated from the data (Charmaz, 2006). Meanwhile Bowen (2008) argues that the emphasis of theoretical saturation is more toward sample adequacy and less about sample size. This means that an important aspect of theoretical saturation is that it is embedded in an iterative process, whereby researchers are concurrently sampling, collecting data, and analysing data (Sandelowski, 1995). This iterative process enables 'theoretical sampling', which

involves identifying concepts from data; these concepts are used to guide participant recruitment to further explore those concepts in subsequent data collection, until theoretical saturation is reached. Theoretical sampling is thereby intricately linked to theoretical saturation to ensure that all constructs of a phenomenon (i.e., issues, concepts, categories, and linkages) are fully explored and supported, so that the emerging theory is valid and robust. Theoretical saturation is therefore embedded in the goals and epistemological approach of grounded theory.

Both Charmaz (1990) and Flick (2002) postulate that theoretical saturation is difficult to accomplish since the researcher will always be left with questions regarding his or her data and therefore theoretical sampling could result in continuous integration of further cases. Charmaz (2006) asserts that theoretical saturation is a subjective exercise and that the constructivist grounded theory method, being an interpretive approach, acknowledges both the importance and limitations of such subjectivity. In this study, the constructivist analytic procedures were followed with diligence coding and memo-writing. Along with these procedures, careful attention was given on the in-depth interviewing approach, particularly on the recognition of varied experiences and expertise of both researcher and participants. All these leads one to conclude that the required depth and rigour have been accomplished in this research.

In the context of this study, codes in terms of how the nurses' roles and relationships in the workplace influence their ethical concerns were identified as: 'unclear role', 'no support', 'conflict with doctor', 'family makes decision', 'patient own body', 'making mistakes' and 'fear of blame'. Theoretical sampling then targeted those who could provide information that enabled the developed categories to be examined further. For example, the theoretical concepts 'unclear role' and 'lack of support' guided me to recruit the assistant nurse to expand understanding on roles between the staff nurse and assistant nurse. It also directed me to recruit a ward manager to understand more about the role they have in the provision of professional support to nurses in nursing



practice. The concepts ‘making mistake’ ‘fear of blame’ directed me to recruit nurses who hold administrative roles in nursing; for example, the Department of Nursing Services. I then further recruited nurses from the Pusat Latihan dan Perkembangan Kejururawatan (PLPK) or Continuing Nurse Education and the Quality Control Unit. Thus, when investigating the category ‘unclear role’, the properties of this category developed from the data where staff nurse and assistant nurse consistently expressed as ‘unclear’; at that point the category was considered to be become fully developed. Once inclusion of additional interview transcripts failed to yield any further insights or results, a decision was made to terminate data collection. It was important to note that such a decision was also partially pragmatic. Firstly, I needed to stop somewhere since there is always the possibility different and non-related issues other than those covered by the participants; secondly I needed to return to the UK in order to attend research training.

### 3.5 USING GROUNDED THEORY

Crotty (1998) suggests that there are four components of the research structure, namely: i) epistemology, ii) theoretical perspectives, iii) methodology and iv) methods that are viewed as related; with each component informing one or more of the others. In selecting a suitable methodology regarding which form of grounded theory to undertake, I reviewed the constructivist’s underlying epistemological and theoretical perspectives. Ontologically relativist and epistemologically subjectivist, constructivist grounded theory clearly reshapes the interactive relationship between researcher and participants in the research process, and in doing so brings the centrality of the researcher as author to the methodological forefront.

Table 1: Research structure	
Epistemology	Constructivism
Theoretical perspective	Symbolic interaction
Methodology	Constructivist grounded theory
Methods	In-depth individual interview (semi-structured)

### 3.5.1 Epistemology

Epistemology addresses the nature of knowledge and provides the philosophical basis for how knowledge is acquired (Crotty, 1998). As this study is concerned with the ways Bruneian nurses make meaning in their nursing practice, constructivist grounded theory is an appropriate epistemology because of its emphasis on the subjective interrelationship between the researcher and participant, as well as the theory's focus on the co-construction of meaning. Researchers, in their 'humanness' are part of the research endeavour, rather than objective observers. Their values must be recognised by themselves, and by their readers, as an inevitable part of the research outcome (Appleton, 1997).

The choices made about the overall research design strategy were guided by my own ontological perspective, which embraces the idea of multiple realities. This underpinned my desire to explore and report on the concept of 'global mindedness', from the multiple perspectives of the participants involved in the study, by using a constructivist approach. I brought a constructivist worldview to the study through my belief that, in seeking understanding of the world in which they live and work, individuals develop varied and multiple subjective meanings of their experiences (Creswell, 2007).

Denzin and Lincoln (2003, p.35) describe the constructivist paradigm as follows:

*The constructivist paradigm assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and subject create understandings), and a naturalistic (in the natural world) set of methodological procedures.*

Constructivism assumes multiple social realities that are constructed by human beings and considers the implications of those constructions for their lives and interactions with others (Quinn-Patton, 2002). Whilst Guba and Lincoln (1989, p. 43) describes constructionism as a research paradigm that negates the existence of an objective reality and emphasised that:

*Realities are social constructions of the mind, and that there exist as many such constructions as there are individuals (although clearly many constructions will be shared).*

According to Charmaz (2006, p.131), the positivist approach to grounded theory lends itself to the objectivist and deterministic approach to research, where it considers the existence of a single interpretation to reality. For Charmaz, both Glaserian and Straussian approaches to treat the researcher as an objective observer may not be plausible. She contends that the interaction between the researcher and participants in interviews cannot be neutral as such. Both Charmaz (2006) and Mills et al. (2006) posit that knowledge is mutually constructed by both the researcher and the participants, and elucidates on how the theory emerges from active engagements between the researcher and participants during the interview process. In other words, constructionism attempts to understand the meaning that is constructed from experience, rather than trying to localise objective truth. It thus follows, that knowledge and meaning are constructed by social actors as they interact, engage and interpret the world they live in. Therefore it is crucial to recognise that meaning is not fixed but changes over time through interactions and reinterpretations.

The research problem shapes the choice of methodology used and, as culture is mostly hidden from its own participants (Hall, 1976), it was my view that a constructivist grounded theory approach was appropriate to employ in this study as it allows for the exploration of cultural complexities and perspectives from the perspectives of the participants themselves; a process described by Hofstede & Hofstede (2005, p.4) as “understanding from within”. My role, as the researcher in this process, was to address the intricacy of these multiple perspectives by listening to the views of the participants, and the meanings they assigned to them, within the context of their own lived experience. I considered constructivist grounded theory methodology to be an appropriate framework with which to address the conceptual nature of the research question itself, which essentially seeks out meaning and understanding.

### **3.5.2 Theoretical perspective**

A theoretical perspective indicates a complex of assumptions underlying a methodology, positing it within a philosophical stance (Crotty, 1998). In this study,

symbolic interactionism is the strand of Interpretivism that has been adopted for this study. Interpretive social science has its origins in German social science and philosophy, in the persons of Max Weber (1864-1920) and Wilhelm Dilthey (1833-1911) and is described as requiring “an empathetic understanding of the everyday lived experience of people in specific historical settings” (Neuman 2000, p.70). Weber strongly emphasised the need for purposeful, meaningful study of social interaction, in order to better understand the reasons for actions. Meanwhile, an interpretive approach has the ability to generate data that recognises the complexity of human perceptions and the meaning constructed through them (Candy, 1989). For example, there is the potential existence of diversity of views among nurses on what they perceived as the ethical dimension; thus this recognition can lead to a greater understanding of what constitutes the values, attitudes and beliefs of the participants in the study. This diversity of views provides the opportunity for me to be flexible and rigorous in gathering views and opinions through interactive and iterative in-depth interviews, thus allowing me analyse and interpret the perspectives of the nurse participants.

The philosophical roots of grounded theory are in symbolic interactionism, which originated from the work by American psychologist, George Herbert Mead (1827-1881) and it was further interpreted by Herbert Blumer (1900-1987). Blumer (1969, p.8) postulates that symbolic interactionism deals directly with issues concerning:

*Language, communication, interrelationships and community... those basic social interactions whereby we enter into those perceptions, attitudes and values of a community, becoming persons in the process.*

Blumer (1969, p.72) describes three basic assumptions about symbolic interactionism:

- 1. That human beings act towards on the basis of the meanings these things have for them.*
- 2. That meanings of such things is derived from, and arises out of, the social interaction that one has with one's fellows*
- 3. That these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounter.*

In essence, grounded theory is generally focused on social processes or actions where it probes on what happens and how people interact. This indicates the influence of symbolic interactionism, a social psychological approach focused on the meaning of human actions (Blumer, 1969). In adopting grounded theory, the researcher commence the interview with open questions, and researchers deduce that they may know little about the meanings that drive the actions of their participants.

It also means that social reality is constructed over time through shared experiences and communications and is then taken for 'reality' (Locke, 2001). Thus, to understand the meaning nurses assign to the ethical problems that they perceived in the general ward settings, interactions of this people must be explored. With the constructivist grounded theory approach, I viewed the construction or co-construction (with research participants) through my interpretation of the participants' meaning. Such meaning relates to the notion of a shared reality that is interpreted or discovered by me and that "...reality arises from the interactive process and its temporal, cultural, and structural contexts" (Charmaz 2000, p.523). Hence, this standpoint refutes the existence of an objective reality, rather assuming that reality, society and the self are socially constructed. Therefore, it is argued that we make sense of our world by developing shared understandings through social interaction with others: a process also known as social constructivism (Gardner et al., 2010).

The constructivist approach also facilitates my understanding of how people negotiate and manipulate social structures; how a shared reality is created and how meaning is developed through social interactions with others within defined contexts. Thus, with this epistemological and theoretical perspective as a guiding principle, it helps to reshape my interaction with participants in the research process, and in doing so creates the notion of myself as author.

In this study for example, I established the relationship that I had with some of the past research literature and practising experiences in general wards and my preconceptions

of the research area. This means that I acknowledged my role as a researcher in the research process as Charmaz (2006) and Strauss and Corbin (1998) do. That is, as a researcher, my interaction with the participants and my interpretation of the data at the later stages of analysis is part of the research process (Charmaz, 2008). This constructivist methodological stance allowed me to position myself carefully with the data and facilitates my theoretical sensitivity to the research inquiry. The table (Table 1) designates the research foundations and involves the four elements that inform one another (Crotty, 1998). Thus, with this epistemology and theoretical perspective as a guiding principle, it helps to reshape the interaction with participants in the research process and in doing so brings the notion of myself as author.

### **3.6 REFLEXIVITY IN QUALITATIVE RESEARCH**

#### **3.6.1 The development of my personal understanding of ethical problems**

I began my nursing education in Brunei with a diploma programme and practising as a general nurse for under four months in 2003 (after graduation). I then continued my first degree at Cardiff University, United Kingdom, for three years under the sponsorship of the Government of Brunei. After completing my one year of a Master in Healthcare Ethics course, from the University of Liverpool in 2007, I started my academic career in a College of Nursing teaching ethics to a group of diploma students. This role progressed to the teaching of ethics to degree nursing students from 2010 until today. My interests in the research study have been generated by my later experiences of teaching ethical problems, which I found were poorly understood. On a number of occasions, students tended to quickly dismiss any ethical discussion on the basis that the topic is relatively straightforward. For example, the issue of a patient's autonomy is not relevant, since Brunei is highly family oriented. In some cases, the students struggled in interpreting and responding to issues, such as confidentiality and informed consent, from an ethical point of view. I was perplexed and started to look for answers, on ethics in nursing practice, how nurses view ethical concerns or challenges

in practice, and how they responded to these concerns and challenges. I became motivated to examine the subject in-depth, so that I could develop an understanding and utilise the study findings to make the ethical dimension in Brunei more visible and valued.

When preparing the research, I reviewed the literature on the subject of ethical problems and nursing. Previous theoretical knowledge and empirical research have increased my understanding of the ethical concerns and challenges experienced by the nurses, their attempts to resolve such concerns, and the moral distress they feel when they are unable to respond to perceived ethical concerns accordingly. With these personal and theoretical preoccupations, I presumed that Bruneian nurses may passively accept and tolerate the ethical problems belonging in the medical domain, and not just nursing per se. Furthermore the status of a medical doctor, which is perceived in Brunei (and many other parts of the world) as far superior to that of a nurse, must have made the situation difficult to address and appreciate. As the study progressed, my understanding of the nurses' own perceptions of ethical problems, and the reasons for their responses, has developed. Not only was the ethical dimension embedded within their roles as a nurse in the workplace, but it was also situated in the nurses' relationship with doctor, patients and patients' families.

The data from this study presents nurses' ideological perceptions of ethical difficulties that they experience or observe in practice, followed by the reasoning on the responses to the difficulties, which enabled me to understand the ethical dimension in nursing practice from a Bruneian context.

### **3.6.2 My position within the research process**

Qualitative research is often criticised as it is thought that the research process lacks scientific rigour when compared to quantitative experimental control studies (Mays and Pope, 1996; Sandelowski, 1986). Reflexivity is concerned with researchers being aware of how their knowledge and clinical experiences can influence data gathering

(Carolan, 2003). In a constructivist grounded theory stance, the role that the researcher plays needs to be acknowledged not only in the process of interpreting the data, but also in the fieldwork, in order to maintain the trustworthiness of the findings (Charmaz and Mitchell, 1996). This means that reflexivity is a constant process that needs to be conducted throughout qualitative research; a process which was fundamental to this study, and which was directly associated with my position in the research process. From the outset of this project, my position as an 'academic nurse studying nursing' has been one of the key methodological issues that I have had to address. The issue of 'insider research' is one that has generated a large amount of literature, crossed numerous disciplines and epistemological positions and played a central role in the concept of credibility. Having had past experiences and knowledge of Bruneian nursing practice, I was acquainted with the socio-political and organisational structure of nursing as practised in the real world of Brunei's hospitals and clinics.

However, later in the process of writing the research proposal, I encountered literature that shifted attention away from simple binary categories towards a concern with the complexity and dynamism of the researcher's position relative to participants, and to the research itself. Re-reading my research diary and the transcripts of interviews through this lens, I realised that much of what I had written reflected a concern with the complexities of my position, which did not fall simply into the binary categories of insider/outsider. This literature helped me to understand my thoughts, actions and interactions throughout the study more deeply, and their influence on the analysis reflected in this thesis. The multiplicity of roles and assumptions brought to the study by the participants and myself also became clearer, as did the power balances that infused our interactions.

I considered myself as an insider. Nevertheless, when it comes to conducting research in the general ward, I was an outsider to the nurses' inner world. The manner in which I presented myself and how I was perceived by the participants were important factors that could exert an impact on the collected data. Thus, it was essential to recognise



my position when faced with participants. With reference to Reinharz (1997), who highlighted the different facets of 'selves', I reflected on my various 'selves' in the research:

1. The research-centred selves: being a doctoral student; being an MSc in healthcare ethics; being a researcher in a medical surgical ward setting; being an interviewer.
2. The brought selves: being female; being an overseas student in the UK; being a nurse teacher.
3. The situationally generated selves: being an insider where I experienced working as a qualified nurse for a brief period, and visited students on clinical placements on a regular basis; as well as having theoretical knowledge in nursing ethics; being an outsider as an academic teacher, being a listener and a friend.

After each interview, I would attempt to write a research reflection on my interaction with a participant or participants, and the influence of my role on that particular situation. An example of my positioning in interviews is illustrated in the following section. In this study, I was engaged in on-going self-reflection, as suggested by Suddaby (2006). This is to ensure that I took personal biases, world-views, and assumptions into account while collecting, interpreting, and analysing data. Such continuous reflection was definitely not easy. I had to be vigilant about keeping every process and decision documented, in relation to the process through which theory was being developed. This audit trail, in the form of memos, is where I wrote personal thoughts, theoretical ideas, and any concerns relating to the research project. Links were made to appropriate documents, categories, and models. Meanwhile, the reflexive mode of constructivist grounded theory also kept the researcher engaged, and interacting with data and emerging ideas, rather than taking a distanced stance towards their studies (Charmaz, 2006). Charmaz (2006, p. 132) maintained that lack of reflexivity can

lead to surfacing and sprouting of the researcher's own implicit assumptions and interpretations to an extent that it may hold an "objective status".

### **3.6.3 An example of my positioning in interviews**

In the earlier interviews, the participants viewed me more as a nurse teacher than a neutral or objective researcher. This was apparent when they hesitated to discuss issues relating to poor practice that they had observed or carried out. This may possibly be the fear that I shared with the ward manager. As an educator and novice researcher, I felt that it was also important to remain mindful of my experience and nursing background, and appreciate the differences between a research interview and giving an academic opinion. It is paramount in the research interview that I avoided, whenever possible, making any comment on academic questions raised by the participants, as this could affect the authenticity of the emerging data.

This procedure was in contrast with Carolan (2003), who seemed to suggest that it is acceptable to exchange information with participants, as this helps to formulate trust and relationships. After sharing a quick reminder of my role as a researcher prior to the interview, or offering a quick reassurance of my aim for the interview, I noticed that participants began to be more comfortable in sharing their views with me. Informed by the paradigm offered by Britten (1995) regarding undertaking qualitative research, I accepted that I needed to critically analyse my interview style, reflect on my participation, as based on the audio recordings, and ask for feedback from academic supervisors. In this particular situation my most significant others were my research supervisors, who had read through the research transcripts and had offered invaluable suggestions to assist with the quality of data collection, the interpretation of emerging themes and my role as a researcher.

## **3.7 SUMMARY**

This chapter has explained a detailed account of the approach taken to this study, its background, methodological and theoretical position and discussed in relation to

the method chosen in the data generation and data analysis procedure. Constructivist grounded theory was the methodology chosen to examine nurses' perceptions of ethical concerns in nursing practice. The following chapter gives a detailed account of how grounded theory principles and practices were employed in this study.

## **CHAPTER FOUR RESEARCH PROCESS**

This chapter details how the principles of a grounded theory approach have been pragmatically applied in this study. It begins with the illustration of data collection procedures including the research setting, practical issues in the process of participant recruitment, as well as sampling and data collection methods. This is followed by data management and translation issues. Details of the data analysis process are then presented.

Data collection for this study took place in December 2011 and then from April to August 2012. Twenty eight nurse participants were recruited. Ethical approval was obtained from the Ethics Committee at the University of Edinburgh and the Medical Health Research and Ethics Committee (MHREC), RIPAS Hospital, Brunei. Participants were approached after permission to access was granted from the relevant gatekeepers in the hospitals. All participants gave their informed written consent to participate in this study. For details of the informed consent forms, see Appendix I. In order to maintain anonymity and confidentiality, the research setting, participants and their workplaces described in the following text are all given pseudonyms. Full ethical consideration is further discussed in section 4.5.

### **4.1 RESEARCH SETTING**

The study was primarily conducted in the main referral hospital which is Raja Isteri Pengiran Anak Saleha (RIPAS) hospital, located within Brunei's capital city. The hospital was officially opened on 28 August, 1984, and is equipped with modern, cutting-edge medical technology. There are over 500 beds available. As the study progressed, participants were also recruited from two other hospitals: the Suri Seri Begawan Hospital, which is the second biggest hospital in the country, with over 180 beds. It is located 107 kilometres from the capital and was established in 1972. The

other hospital is the Pengiran Muda Mahkota Pengiran Muda Haji Al-Muhtadee Billah Hospital, which is located 40 kms from the capital. The hospital was built in 1997 and has over 130 beds available.

## **4.2 PROCESS OF RECRUITMENT**

My participant recruitment began in November 2011, when a letter was sent to the Department of Nursing Services to explain the purpose of my research. I also contacted the hospital administrator at RIPAS hospital for permission to use research flyers with the official hospital logo stamped on them, before distributing them around the medical and surgical wards. The research flyers were to inform the potential participants of a series of recruitment briefings which were to give potential participants the opportunity to learn more about the study. Unfortunately, there was a poor response rate for the arranged session, at which there was only one attendee. Perhaps I overlooked the reality that getting volunteers for a research study is not clear-cut. Possible reasons for a poor response rate may include lack of interest, inappropriate timing (both morning and afternoon sessions were carefully selected so as to give nurses from all shifts the opportunity to attend), and, most importantly, my reluctance to use any personal network to gain access; rather, I preferred to use a formal approach. I then had a discussion with a senior working colleague who further advised to approach the nursing authority. I then learned that, at times, approaching personnel with authority can help to kick-start the recruitment process, and that there is a “channel” to go about recruiting is not always clear, especially to a novice researcher. This was illustrated when the personnel gave a direct order to the subordinates to enlist a number of nurses to attend the briefing session based on the main criteria that the native to-be-recruited nurse is presently working, or had formerly worked, in the medical or surgical wards for at least ten years.

#### **4.2.1 Access to participants**

As part of the initial recruitment using purposive sampling, I intended to recruit around ten nurses who were working in the medical surgical wards only. This was not feasible, however; hence, I included those who had some medical and surgical ward experiences. Meanwhile, restricting participants to those who had at least ten years working experience also proved to be impossible, and therefore I reduced it to at least three years of working experience. The decision to participate in the research was however entirely the nurses. The demographic characteristics of the sample included years of experience working in nursing, gender and post (see table 1). This information is essential in helping the reader to visualise the context from which the theory and its specific categories were developed. The co-constructed core category in this study is a substantive theory, because the theory evolved “from the study of a phenomenon situated in a particular situational context” (Strauss and Corbin, 1990; p.174).

During the recruitment session, I individually distributed letters of invitation to take part in the study and information sheets as well as a consent form. All these documents were made available both in Malay and English (see Appendix H and I). Participants were given the option to notify me of their decision; either at the same time, or I would contact them through a phone call within a week to find out if they were interested in becoming a participant. From there, arrangements were made for the interviews to take place, whilst the consent forms were signed prior to the start of the interview session.

Based on the sessions, it was not easy to convince the potential participants to participate in the research, because of the implications if the nurse in authority were to learn their identity. This will be discussed further in the ethical consideration section. At one point, I also felt the fear of possible rejection from the potential participants. In the sessions, some volunteers wrote down name and contact number, whilst others were uncertain but did not mind if I were to contact them for a follow-up discussion. A week after the briefing session, follow-up arrangements were made for the interview to

take place. Some had verbalised the wish to withdraw for a number of reasons. In the purposive sampling session, which took place in December 2011, a total of nine staff nurses were interviewed. Six of the nurses were currently working in general wards, whilst three had previously worked in general wards. Only one session consisted of two nurses upon their request. The rest were individual interview sessions.

After each interview on purposive sampling, I tried to comply with the principles underpinning theoretical sampling outlined by Glaser and Strauss (1967). This ordering was done by performing data analysis as soon as the interview ended, in the form of coding and categorising the data, which allowed me to return to the field to obtain further categories. Inadequate theoretical sampling could lead to a formal theory not being developed or being developed prematurely (Strauss and Corbin, 1990; Charmaz, 2000). However, this procedure of prompt data analysis was not strictly observed, as sometimes it proved to be a relative challenge when there is short gap between interviews, which prevented a comprehensive data analysis. To address this, I wrote down a fieldwork memo which helped me to do a prompt analysis, guided me to obtain further categories, as well as guiding me regarding the next participants to be interviewed.

When I first recruited the participants, there were a number of practical issues that had to be dealt with. I came to learn that it was not easy to convince the busy nurses to give me an hour or more of their lives and to answer my questions. However, it seems persistence plays an enormous role in securing interviews, a little time was spent on contacting the potential participant and some follow-up communications via mobile phone texts were also involved. Only after a series of exchanges via mobile phone texts was an interview date fixed. The invitation letter needed to be handed in person for some interviewees, particularly in situations involving powerful people, where it is preferable to make first contact by a direct visit to that person.

In some instances, where participants could not make it, they would nominate other personnel to be interviewed instead. In some cases, participants preferred to reschedule appointments at short notice, which made things difficult for me, but which served as a salutary reminder of the realities of field-based research. This difficulty was because finding a slot for rescheduling can be a relative challenge, particularly when I needed to drive long distances for the interviews. Of course, I was ready to have appointments cancelled at any moment, even at the time when I arrived for an interview. Another aspect of this study that required my patience was interviewees not keeping to the time arranged; I did not expect punctuality, particularly when they just had ended their shift. Nevertheless, I always gave myself plenty of time to arrive at an interview, especially when I was travelling to an unfamiliar location. I always found it useful to reconfirm interviews two days before if a long time had passed since they had been scheduled.

In January 2012, I had to return to Edinburgh to attend research training on analysing qualitative data. Once the training had been completed, I returned to Brunei to continue the fieldwork in April 2012. Similar to the previous recruitment briefing, the criteria had changed slightly because of following the theoretical sampling principles. From April 2012 to August 2012, I had managed to interview nurses with numerous roles and responsibilities, such as assistant nurses, graduate nurses, ward managers, as well as nurses from different units such as the Nursing Board for Brunei (NBFB), Pusat Latihan dan Perkembangan Kejururawatan (PLPK) or the Continuing Nurse Education Centre and Quality Unit. I also recruited potential participants from two other teaching hospitals, namely the Suri Seri Begawan (SSB) hospital, which is located in Belait district, and the Pengiran Muda Mahkota Pengiran Muda Haji Al-Muhtadee Billah (PMMPMHAMB) hospital, which is located in Tutong district. The remaining hospital, which is located in Temburong district, was not selected merely because of its relatively distant location. The responses I received were promising; nineteen nurses were interviewed during the period of April to August 2012. The interview period was



extended to August 2012 because of the difficulty of finding an appropriate date for the interviews. This is because some participants were busier than others.

Throughout the fieldwork period, potential participants were either recruited when they attended the recruitment briefing or when an invitation letter was sent to them, based on the need to further explore the research data. One nurse, who met the criteria, volunteered to participate despite not attending the briefing. I also received a few expressions of interests from other nurses, but unfortunately, they did not meet the criteria; for example, they worked for semi-government hospitals, which meant that the administrative aspect of getting access, and having a different hospital policy and procedure in place, may just have delayed the recruitment process.

As the study progressed, I invited nurses from other departments, for example the representative from the Nursing Board for Brunei Darussalam to further understand the points given by the participants in the previous interviews. Nursing Board representatives were invited because of the roles that the Board had in shaping the code of ethics and code of conduct of the nurses. In total, twenty-eight nurse participants were recruited and completed written consents as eligible to participate in the study. Table 2 illustrate the participants' profile.

**Table 2: Profile of the participants**

NO.	NAME	GENDER	POST	AREA OF WORKING	YEARS OF WORKING
1	Latifah	Female	Staff Nurse	General Ward	+10
2	Zaitun	Female	Staff Nurse	General Ward	+10
3	Sarimah	Female	Staff Nurse	General Ward	-10
4	Ramlah	Female	Staff Nurse	General Ward	+10
5	Normah	Female	Staff Nurse	General Ward	+10
6	Rosnah	Female	Staff Nurse	General Ward	+10
7	Daud	Male	Staff Nurse	General Ward	+10
8	Samsudin	Male	Staff Nurse	General Ward	+10

9	Mariani	Female	Staff Nurse	General Ward	-10
10	Mariam	Female	Staff Nurse	General Ward	+10
11	Ramli	Male	Assistant Nurse	General Ward	+10
12	Saadiah	Female	Staff Nurse	General Ward	+10
13	Fauziah	Female	Staff Nurse	General Ward	+10
14	Omar	Male	Staff Nurse	General Ward	+10
15	Rafidah	Female	Staff Nurse	General Ward	+10
16	Aziz	Male	Staff Nurse	General Ward	+10
17	Junaidah	Female	Nursing Officer	General Ward	+10
18	Aini	Female	Staff Nurse	General Ward	+10
19	Halimah	Female	Assistant Nurse	General Ward	+10
20	Faridah	Female	Staff Nurse	General Ward	+10
21	Sanisah	Female	Staff Nurse	General Ward	+10
22	Masnah	Female	Nursing Officer	Administration	+10
23	Kalsom	Female	Staff Nurse	General Ward	+10
24	Khadijah	Female	SNO*	Administration	+20
25	Azean	Female	SNO*	Administration	+20
26	Saloma	Female	Nursing Officer	Administration	+10
27	Fatimah	Female	SNO*	Administration	+20
28	Maimunah	Female	Nursing Officer	Administration	+10

#### **4.2.2 Preliminary interview**

During the summer of 2011, I had the opportunity to conduct a preliminary interview. This interview was carried out primarily to identify possible hitches in research design and an attempt try my interview skills, as well as the use audio recording sets and microphones. It is important that the sound system is sensitive enough to pick up any changes in the tone or pitch of a person's voice. The preliminary interview was positive and enlightening, despite my initial anxiety and the anxieties demonstrated by the participant (nurse colleague), who was keen to share her experiences. She answered my question with a question, as if she was looking for clarification or prompting me for answers about her situation.

As a result of the preliminary interview, I chose to proceed with semi-structured interviews. I decided to use the digital audio recorder with a small pencil slip microphone as both of these could be placed out of sight, if necessary, and still record the conversation. Time limits were checked during the pilot; therefore, it gave me an understanding of how much time would be needed to work through the areas I would like to discuss.

After careful deliberation, I opted to type the transcripts myself, which allowed me to be completely immersed in the data. This immersion was also accomplished by revisiting the typed transcripts and the digital recorder in order to identify and clarify significant statements.

### **4.3 DATA COLLECTION METHOD**

To generate data, each participant was interviewed face-to-face for about 60 to 90 minutes, at a time convenient to both me and the interviewee. All interviews were completed in one session, unless a further interview was warranted. This is in line with the thoughts of Glaser (2005) who opposed returning the transcripts to the participants for verification to increase accuracy in a study. This opposition was based on the possibility that even more information may only overwhelm the researcher with descriptive data which does nothing to aid the generation of theory.

Fontana and Frey (2005, p.698) stated that:

*The focus of interviews is moving to encompass the hows of people's lives... as well as the traditional whats.*

These hows and whats are exactly what I am seeking. The interviews are done individually rather than using a focus group. Although focus group interviews are seen to be relevant for collecting data at the beginning of a study, they can also lead to a large amount of data from a few focus groups which can delay the start of theoretical sampling. This will then lead to the premature closure of data collection, leading to a

lack of conceptual depth (Pergert, 2009). Furthermore, in my opinion, it would also be impractical to gather the nurses at one time because of their different working hours.

The initial interviews were exploratory in nature whereby the interview topic guide was adhered to, as generally and as openly as possible, because interviews rely on emergent data to stimulate and generate discussion on the topic as relevant and important to participants (Carey, 2010). The order in which the various topics are dealt with, and the wording of the questions, were left to my discretion. Within each topic, I was free to conduct the conversation as I saw fit, to ask the questions I deemed appropriate in the words I considered best, to give an explanation and ask for clarification if the answer was not clear, and to prompt the participant to elucidate further if necessary. I also anticipated additional questions to be asked by participants. At the same time, I probed for views and opinions, using probing as a way to explore new paths which were not initially considered (Gray, 2004, p. 217).

At the outset of the study, participants were asked four general, open-ended questions. The research question was: “What is the nurse’s ethical dimension in general wards?” The following four general questions were asked at the start of the study, in order to explore the research question with participants: (1) how do you describe your job as a nurse, (2) what is the most difficult situation you are involved with in the ward setting? (3) how do you respond to that situation? (4) what are the reasons for your responses? These general questions were effective in eliciting rich and dense descriptions of ethical dimensions in the ward setting. For the subsequent phase of the interview, the interview guide was continuously revised by adding or modifying questions related to the concepts that surfaced in previous interviews, until theoretical saturation of the developing categories occurred. This was in keeping with the principle of theoretical sampling.

On reflection, the drawbacks of semi-structured interviews were my own inexperience, which perhaps prevented me from being able to ask prompt questions or probe into a

situation. For example, if a participant expressed her frustration over the current state of nursing, there is a need to probe and find out the reasons for that frustration and to ask for further explanations.

Meanwhile, to capture the meanings of narratives in context and not lose nuances embedded in the language used, the interviews were recorded and conducted bilingually, but mostly in Malay, which is the native language of the participants and the interviewer. The findings and quotations was translated into English, after their meanings have been analysed in the Bruneian linguistic context. None of the participants objected to the use of an audio-recorder during their interview. The use of a mini microphone was useful in filtering unnecessary noises. Glaser (1992) however believes that taping produces too much data, without refining the main ideas. I somehow concurred with this, but in my opinion, taping was important as a back-up, particularly where I missed a point during the interview. On the other hand, I found that the need for transcription between data collection and data analysis slowed down the interview process, for I was unable to begin another interview until the previous transcriptions were available. This hold up was simply because some of the interviews took place one after another with a short gap in between. To tackle the potential hold up, field notes played an important role, as I tried to write them straight after each interview.

#### **4.3.1 Data management**

The twenty-seven interviews were all transcribed and translated verbatim by myself. The transcribing process allowed me to interact closely with the data and to identify the underlying meanings from the participants' words. The recording of each interview was transcribed into an electronic format to enable clear examination and analysis of the data. During the qualitative analysis training course, I started to learn how to use NVivo software and how to transfer the codes to the programme. The idea of this software is to store and organise the various nodes derived from the data. The software proved to be very exciting to learn and use in the beginning; however, as the process

of coding proceeded further, I began to struggle in making sense of the complexity of the software, which I felt to be too mechanistic. Not giving up too soon, I gave myself a few more attempts, but the progress was rather slow.

Without wasting any more time, I decided to abandon the software totally and worked out how I could start using word processing, something that I was more familiar with, in organising the data. Based on the experience of LaPelle (2004), I started to create tables, which consisted of five columns, namely participant's identification, interview extracts, initial codes and memoing. This was done by transferring the interview transcripts into the tables. It was far more reassuring for me, because everything was done in the same table, where the codes and texts were numbered accordingly; annotation and memoing were written to correspond to the identified codes. This meant that there was no need for separate links for those features as in NVivo software.

I feel that the process of using the traditional approach of word processing, rather than the "contemporary" approach, made my research analysis much easier and more structured than if I had used a computer analysis programme. Some of the reasons for this perception are that, first, while NVivo allowed me to link together the codes and memos from the transcripts in a retrieval format, I still find this is possible in word processing, through the hyperlinking feature. In order to ensure that the codes from the transcripts were chronologically ordered, the codes and the transcripts were numbered accordingly; hence, tracking them would be easier for future use. Secondly, the "cut, paste, copy" as well "find, replace, select" features of word processing proved to be efficient in transporting the codes into another new table, which was later written on Post-It notes manually and analysed. Thirdly, the process of monitoring the development of ideas, theoretical frameworks, gaps in the literature, as well as potential interview questions, was made possible with the use of the date/time feature.

#### **4.3.2 Translation issues**

Transcription that encompasses translation from one language to another presents an especially complex and challenging situation. During the interview, I generally gave the participants the option to choose the language medium, either in the first language, Malay, or in English. Such option would allow them to express themselves freely, without feeling restricted. All participants chose to express themselves bilingually. The transcripts were first transcribed and later translated into English. In doing my own transcription work, I gained greater familiarity with the data, as well as deeper insights. However, the translation process took most of the time since all translation was undertaken by me. Whilst the meanings have been analysed in the Bruneian linguistic context, there were several occurrences where I encountered words which I was not certain how best to fit grammatically correctly into the English language. For example in Brunei, when a participant says “Patients are making demands”, demands can be understood as ‘belabih’ in Malay; or when one is not interested to listen to others’ suggestion, the person is said to be acting ‘gagah’. In both instances, the words ‘stubborn’ and ‘being assertive’ were considered to indicate ‘belabih’ and ‘gagah’, but both words seemed not fully suitable to express the intended meaning. The advantage, nevertheless is that I speak, read and write Malay fluently, and this has been invaluable; particularly when majority of participants were comfortable in speaking in Malay. Language and cultural differences were minimal, in comparison to what they would have been, if I had been an outsider conducting this study in Brunei. Once translated, the supervisors checked the English transcripts to ensure quality control monitoring.

#### **4.4 DATA ANALYSIS**

The analytical procedure started with a transcription and review of the first interview. Data collection and analysis were undertaken simultaneously (Glaser and Strauss, 1967) as described in the sampling Section 4.4.3. Constant comparison and memo writing were conducted throughout the study to assist the analysis process. In keeping

with the grounded theory approach that I adopted to carry out this study, the interview transcripts were processed and analysed through the coding procedure.

#### **4.4.1 Coding**

During coding, the researcher generates the bones of analysis which will then be integrated and assembled at the stage of theoretical coding which is crucial for identifying emergent themes for further analysis and subsequent theory development Bryant and Charmaz (2007, p. 45). Coding follows from a detailed analysis of the data obtained from interview transcripts whilst codes are expressed in the form of short phrases called concepts. Whilst it is the researcher's choice as to whether to assign new labels or utilise the exact expressions (in vivo codes) employed by the participants (Charmaz, 2006, p.55), the labels should be able to describe the underlying data and also suggest meanings and actions.

There are different stages of coding. For this study, Charmaz's coding process was employed to guide me in conducting the data analysis. Charmaz (2006, p.49) identifies the following fundamental concerns that need to be kept in mind during coding: remain open (whilst also recognising the difference between an open-mind and an empty-mind, as openness here refers the importance of allowing concepts to emerge and not forcing preconceived concepts onto the data), stay closer to the data; use simple, short and precise codes; preserve actions (use of gerunds), ensure constant comparisons between responses and concepts; and move quickly through the data; capture or condense meanings into "compelling codes that capture the phenomenon and grab the [attention of] the reader" (Charmaz, 2006, p. 48). Given the cyclic nature of the grounded theory approach, while the coding processes are presented sequentially in the following text, these occurred iteratively in practice.

##### **4.4.1.1 Initial Coding**

Initial Coding was the earliest stage, at which the data was broken down into units, was labelled, conceptualised and compared for similarities and differences (Strauss and



Corbin, 1998). The choice of conducting the transcription and translation by myself entailed my immersion in the data and prompted me to identify the recurring themes, similarities and differences within and across the interviews. Such immersion also enabled me to recognise the gaps in the data, to extract the data, and then guided me to collect the needed data in the following stages.

Meanwhile the size of the data unit for coding can vary from word to word, line by line to incident by incident, depending on the nature of the data (Charmaz, 2006). Line-by-line coding is generally recommended by grounded theorists for the detailed data of “fundamental empirical problems or processes” (Charmaz, 2006, p. 50). This type of coding helped me to see the nuances in the data, but also to remain critical about it by keeping myself from being overly immersed in the participants’ positions.

The stage of Initial Coding involves the development of categories through a process of classifying and categorising concepts. Appendix E uses the refined category ‘nurse at work’ as an example to demonstrate the development of a category in the coding process from the raw data, initial codes to the category. My analytical thinking about the generation of the category (‘workload’) is demonstrated in Memo Appendix E. During the classification and categorisation of data codes, the Initial Coding was grouped into twenty six abstract concepts (see Appendix F).

During the coding process, I also searched for missing information. There were instances where some participants appear unwilling or afraid to discuss, particularly when it involves potentially serious clinical incidents. This was obvious when interviewing nurses of senior rank. I noticed that some participants would start to become defensive, and verbalise that “everything seems to be in control”, that “everything has been in place to tackle any shortcomings”. I believe that in these conversations, the participants felt a strong compulsion to avoid discussing sensitive issues. It may be that they did not trust me, but I highly suspect that these participants might be thinking about the repercussions if they revealed those sensitive issues. Spradley (1979) noted that when

people tell stories, they assume that their listeners share many assumptions about how the world works, and so they leave out information that “everyone knows”. He called this process abbreviating. Meanwhile Allan (2007) recommends that, during Initial Coding, the researcher should keep asking: “What is actually happening in this data?” This will continually remind the researcher of the original research intentions and aids the researcher to stay in focus without getting lost amongst masses of data.

It is worth stating that each Initial Code is linked to the sentences, paragraphs or short excerpts of interview transcripts with which it is associated. Meanwhile Initial Coding was undertaken in Malay in order to preserve the original meaning of the participants’ account. These initial codes were then translated into English for further analysis. One example of the coded interview transcripts is provided in Appendix C. Hence, a total of 600 codes were established at the earliest phase, but during the classification and categorisation of data codes, the codes were grouped into twenty six abstract concepts (see Appendix F). The coding step then progressed to a more refined coding stage, called Focused Coding.

#### **4.4.1.2 Focused Coding**

Upon the completion the Initial Coding stage, Focused Coding of codes and concepts is employed to identify developing conceptual categories. Appendix F provides a summary of the coding process, showing a link from the development of the initial codes to the concepts, and to the conceptual categories at Focused Coding.

In the process of coding, three dimensions of nursing practice were perceived as ethical dimensions, namely the ‘nurse at work’, which elaborates nursing work in the ward. The second and third is ‘nurse and doctor’ and ‘nurse and patient’ which interplay with each other to demonstrate further ethical dimension underlying nursing practice. The strategies, ‘taking responsibility’ and ‘shifting responsibility to others’ represent the approaches where participants employed to response to the ethical dimension issue. The reasoning behind the approaches varies, but primarily based on the elements of

minimising conflict, and maintaining harmony. As a result, these elements exemplify the understanding of nurses' responses to the ethical dimension in nursing practice which result in the core category of 'negotiating ethical responsibility'. Eight conceptual categories and six refined categories were constructed and interrelated in Figure 1. The relationships between these categories and sub-categories are marked by the arrows. The figure illustrated the refined categories to be organised in a logical way and the relationships among these categories to be presented clearly.

**Figure 1: Relationships of the Core Category and Categories**  
Key concepts generated by data

Ethical Dimensions s	→	Nurse at work	Nurse and doctor	Nurse and patient
Ethical Responses	→	Taking responsibility And Shifting responsibility to others		
Reasoning	→			
Core Category	→	<b>NEGOTIATING ETHICAL RESPONSIBILITY</b>		

#### 4.4.1.3 Theoretical Coding

Whilst Focused Coding facilitates the organisation of the codes and concepts that was established during the Initial Coding stage, Theoretical Coding is the subsequent stage of coding which enables further analysis of conceptual codes into higher level categories and the saturation of the conceptual categories identified during Focused Coding. The use of memos and constant comparison between focused codes were instrumental for theoretical coding. During each of these

refinement and saturation processes, the analysis moves from mere description to conceptualisation.

For this study, the analyses resulted in the co-construction of six refined categories ‘nurse at work’, ‘nurse and doctor’, ‘nurse and patient’, ‘taking responsibility’, ‘shifting responsibility’ and ‘conflict- harmony paradigm’. These refined categories represent the overarching themes discussed by research participants. The terms or concepts associated with each refined category were not necessarily identical to those mentioned by all participants; nonetheless iterative conceptualisation indicated that these refined categories subsume within them the underlying concerns of participants in the context of perceiving and responding to ethical dimension in nursing practice. Subsequent chapters discuss these refined categories fully. Furthermore, the relationships among these six refined categories are elaborated.

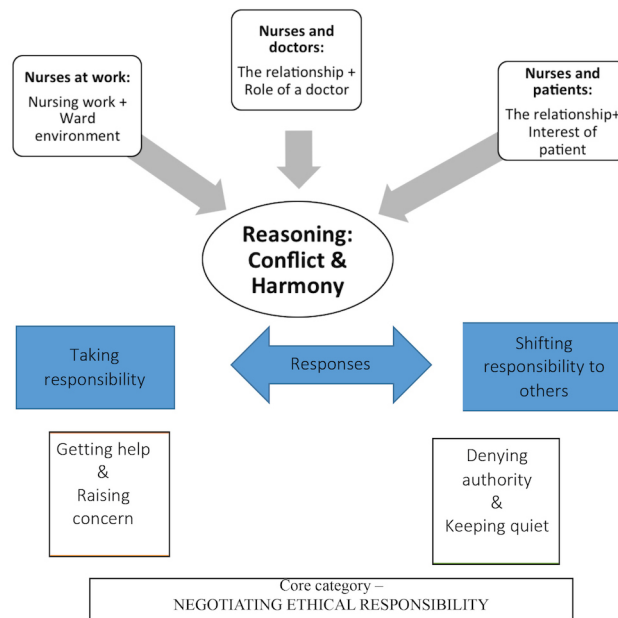
In order to be able to allow concepts to be co-constructed and identify the refined categories, memo writing technique of constructivist grounded theory was adopted, starting from the early stages of the research endeavour. These memos helped me to explore what lies beneath the responses of participants, relate and compare various responses, and discover conceptual themes.

The process in Theoretical Coding includes ‘integrating and refining categories’, as well as identifying the core category whereby the theory is constructed (Strauss and Corbin, 1998, p. 143). Charmaz (2006) acknowledgement of the role of the researcher in theory construction is evident in this coding process, when the researcher selects a category that has the ability to integrate all conceptual categories to develop an explanatory story.

In this stage, the core category of this study was identified as ‘negotiating ethical responsibility’, which was central to all other categories and which linked them together. The relationship of the core category and categories has been presented in

Figure 1. Meanwhile to explain how nurses tried to reason with the response to an ethical issue in practice, the core category was further interpreted and presented by diagramming (Figure 2), showing that the nurse was negotiating ethical responsibility whilst taking into account the two elements, namely avoiding conflict and maintaining harmony. All of the participants' transcripts were presented and locate themselves somewhere within the core category. The explanation presented here is to help the reader appreciate the analytical process. The subsequent findings chapters will present evidence in detail regarding how the findings relate to the development and refinement of the core category.

**Figure 2: Core category— ‘Negotiating ethical responsibility’**



#### 4.4.2 Constant comparison

Constant comparison is an essential technique in grounded theory to enable the researcher to systematically sort large volumes of raw data. During the coding process, data were continually examined and compared to each other, to identify similarities and differences, in order to form meanings and develop theoretical concepts (Strauss and Corbin, 1998). This technique entailed an iterative process of analysis for this

study, which compared data at each analytical (coding) level, and across different levels, until the core category was developed.

#### **4.4.3 Memo writing**

Memo writing worked throughout the analysis process. It creates an ongoing dialogue between the researcher and the data to record the researcher's understandings of, and insights into, the data, so refining the emerging categories and primary theory (Charmaz, 2006). This technique allowed the researcher to analyse, question and clarify meanings generated from the accounts of participants and the analytical interpretations of the researcher (Charmaz, 2006). During the study, memo writing enabled me to record my analytical thinking, to reflect and refine the research procedure and to gain deeper insights into the participants' experiences, perceptions and behaviours in relation to the research inquiry, and the context within which the core category was developed. Considering Charmaz's (2006) suggestion, the research memos were recorded more freely in order to grasp the momentary thoughts of the codes, the developing categories, and the relationships between categories, as the study progressed. An example of a memo is presented in Appendix E.

### **4.5 ETHICAL CONSIDERATIONS**

#### **4.5.1 Ethical requirements**

This study undertook two phases in gaining ethical clearance. The primary ethical approval was obtained from the Ethical Committee of the School of Health in Social Science at the University of Edinburgh, where I am studying for a doctorate, and the Medical Health Research Ethics Committee (MHREC) of the Ministry of Health, Brunei, where the participants work (see Appendix G). Access to the potential participants was achieved by consent from relevant gatekeepers in the hospitals and nursing departments, and from the participants themselves (for information sheets to the relevant gatekeepers and participants see Appendix H; and consent forms see Appendix G). The ethical considerations for this study drew on the principles of

the Research Ethics Framework stipulated by the Research Ethical Committee of the School of Health in Social Science at the University of Edinburgh (2008). With reference to this framework, ethical recruitment, protection of participants from harm and respect for anonymity and confidentiality are addressed in the following text.

The potential ethical issues, in terms of the recruitment of the nurses, have been acknowledged and addressed in Section (4.2). Careful thought and strategies in terms of the relationship between the researcher and the participants, during the research process, have also been considered in section (4.2) and section (4.3).

#### **4.5.2 Informed consent**

During the recruitment briefing, potential participants were informed of the purpose of the research and the role of the participants in the research. I was careful to balance the need to provide specific details about what would be expected of them in the study, because it may jeopardise the data with some text-book answers (Carey, 2010). I also made it clear that this study would provide no direct benefits to them, and that payment for participation is inappropriate. Nevertheless, I convinced the participant nurses of the merit of this study and shared with them my own experience of being a research participant. As an incentive for their participation, the Pusat Latihan dan Perkembangan Kejururawatan (PLPK) or Continuing Nurse Education awarded four credit points for their research participation.

Participants were informed that they are free to withdraw from the study at any time they wish. Emphasis was made that they should not feel obligated to proceed with the interview if they wished to withdraw from the research for whatever reason, and that their participation was purely on voluntary basis. From experience, there appeared to be a tendency among participants to explain the reasons for withdrawing. Only a few of them decided not to pick up their phones or reply to the text messages. After a third attempt to contact the potential participants, I no longer made any further follow-up attempts. Such attempts may appear to be forceful, but these are perhaps justified on

the basis that the participants could be busy or could have forgotten to return or reply to the call or text messages. When a nurse agreed to participate, consent forms needed to be signed prior to the onset of the interview. This means that interviews will be conducted when participants feel able and willing to share their feelings and thoughts on the topic.

#### **4.5.3 Anonymity and confidentiality**

The issues of anonymity and confidentiality were addressed in a variety of ways throughout this study. Polit and Beck (2006, p. 89) described confidentiality as the “protection of study participants such that individual identities are not linked to information provided and are never publicly divulged”. One aspect of confidentiality that concerned me was when a nurse in authority specifically requested the names of volunteers to be submitted via her to the Pusat Latihan dan Perkembangan Kejururawatan (PLPK) or Continuing Nurse Education (CNE) Centre for the credit point reward. To avoid any friction of opinions, I agreed to this. Furthermore, the names of participants had to be submitted to the relevant department in order to reward the nurses with CNE points. Nonetheless, I clearly informed the participants about these issues and their consent was paramount. More than half of these participants stated that their names are not to be disclosed at all. Furthermore, they felt that they took part in the research out of genuine interest and because they felt they have something to share. The rest did not mind at all; after all, the CNE points would be helpful for their professional development. They, however, needed to be reassured that the authorities would not know who said what. Nevertheless, the participants were given opportunity to choose which option they would take.

Another challenge was when, on some occasions, the nurses in authority from certain wards, or nurse colleagues working in the same ward, tried to ask informally if their staff or colleagues have participated in the research. It is charitable to suggest such enquiries were made out of curiosity. Furthermore, being in a small country with a



small population, particularly in the hospitals where it is almost impossible not to know each other, it is not surprising that one's participation can be easily determined. I would politely respond by explaining the reason that I cannot answer and that it is preferable to ask the person herself, to which they would reply with a smile and not ask further.

When it comes to the publication and dissemination of the research findings, some nurses expressed their concern over whether they could be easily identified as an 'informant'. Normally this query happened before they were about to share a piece of information that was perceived as sensitive. For example, the nurses shared a number of clinical incidents which they perceived as possible contributing factors that caused harm or even the death of patients. Some nurses were also open and honest in speaking about the political nature in the ward as an organisation, particularly when it concerns career advancement and opportunity. On several occasions, participants tend to whisper or lower their voice when it came to sensitive information. I reassured them that their identity will remain anonymous and every aspect of privacy will be strictly observed so that their identities would not be easily determined.

On the other hand, one of the many aspects that concerned me the most was the location of the interview. The use of an allocated sister's office and a meeting room brought about uncomfortable situations for me because I tried to maintain the confidentiality and identity of the participant. This was particularly the case when some health personnel interrupted the interview session when they accessed the room. When that happened, I would ask politely if the participant wished to stop the interview temporarily. On a few occasions, participants just continued to speak despite the presence of other personnel, provided that it was not anything sensitive, while the rest would only continue with the interview once the personnel left the room. Throughout the interruptions, I felt uncomfortable when the identity of the participant was "known" by the personnel, even if they may not know the purpose of the interview. According to several participants

such as Aziz and Zaiton, they volunteered to tell colleagues about their participation in the research. Furthermore, an attempt to lock the door throughout the interview session would not be practical, particularly when the personnel needed to access the office to carry out daily administrative work. Perhaps it was just me who felt uncomfortable, because the majority of the participants did not appear concerned. I, however, would not be surprised if nurses in each participant's respective ward knew that that particular nurse took part in the research. Hence, the guaranteed provision of anonymity was understandably a concern for me as a researcher, however does not appear to be the case for participant's perspective. Burns and Grove (2005) stated that all participants have the right to privacy, anonymity and confidentiality; however, they also stressed that true anonymity exists only if the participants' identity cannot be linked to the data, even by the researcher. To further protect the identity of the participant, the data was transcribed and later translated by me, and not passed on to a translation service. This was, however, because I was in a better position to translate the context of the participants' interview account than the service provider.

Meanwhile, ultimate care was also taken when keeping copies of the digital interview recordings and transcripts under secure conditions. For instance, the digital recordings were stored on a personal computer and portable device (such as portable hard disk) with password protection and appropriate secure storage. Pseudonyms were assured throughout the research process to maintain absolute confidentiality. In data that may be published in a journal or elsewhere, the participant's names or their identity will not be disclosed.

While it may not be anticipated, interviews can provoke strong emotional feelings. Any research has the potential to cause distress; Streubert and Carpenter (1999) stated that time must be made available at the end of the interview in case the participants require help. Management of this potential stress should not be underestimated and, if required, appropriate techniques should be planned. In addressing this, I have had

reflective discussions with academic supervisors and colleagues who have done data collection before. This helped me to prepare for any eventualities should they happen. To minimise any form of stress or exhaustion during the interview, I informed the participants that the duration of the interview is expected to take 60 to 90 minutes; during this study, the shortest interview took just under an hour and the longest interview took just under two hours. Some interviews had to be longer because of the small-talk in between specific points, or when the incidents mentioned were deemed sufficiently important to be explored. To avoid any risk or burden to the participants, they were given the freedom to choose the timing of the interview, although some did not really mind when the meeting would happen. They were encouraged to choose for either the interview to take place on their day off, before an afternoon shift begins, or simply during lunchtime. Most participants, however, chose to have the session during or after their morning shifts. When that happened, I always made a point of asking them, prior to the interview, to verify that they were in good health and not feeling exhausted, so that they could focus on the interview.

Participants were given the option to select the day and time of the interview; however, the preferable options were before the shift started, during lunch hours or on the day off. This would prevent me from interviewing them while they felt tired, which could have potentially affected their focus. In most cases, one of these options was chosen, but in several cases these hours were not practical, hence some interviews took place after the shift ended. Throughout the fieldwork, none of the participants showed any form of stress or exhaustion.

Meanwhile, the hectic schedule of the nurses meant that there was a last minute rearrangement of interview dates, which meant the room booking had to be organised on short notice, particularly when the room was used for meetings. The result was that some interviews were conducted on the same day with only a small window of time to do data analysis before the next interview. I had to travel long distances to meet

nurses who worked outside my district. Many nurses I met did not have much free time and I had to fit my interview around their working hours. Whilst I was not keen to interview them after their shift, because they may have been tired and may not be able to focus on the interview, for some that was the only option. One nurse was willing to be interviewed after night duty, which fortunately did not affect her focus at all. Many expressed that leaving the ward whilst working was impractical and not feasible. For those nurses who worked on an office hour's basis, 1½ hours interview was made possible during the lunch break.

#### **4.5.4 Sensitive information**

Whilst the safety of participants throughout the data collection was considered, another aspect that arose during the interviews was whether there was a need to report to relevant authority when participant disclosed stories which may be concerned on patient well-being and safety. In this study, some of the patients were epitomised as deemed at risk from poor nursing care, or dangerous practices of the nurses, for example, when they verbalised on the practices of cutting-corners when performing nursing duties. These sensitive materials may suggest harm towards patients. Hence, this led to be asked myself to ask my own responsibility as a researcher.

After a careful consideration and given the principles of privacy and the maintaining of confidentiality, I decided not to disclose or share such materials with the ward manager. Whilst it was not mandatory to report such sensitive materials, there may be an obligation to encourage the nurses to speak or reflect about the dangerous practices or unethical nurse as a form of debriefing, so that the risks of harming the patient is addressed accordingly. The handling of such sensitive information entails me to engage in an “informal” chat after the interview session ended, so that I could speak appropriately with the participants. It was my hope that the participants can make informed decisions about addressing the sensitive information with the relevant

authority. On the other hand, if I were to make report, it may be also be difficult to recruit future participants, or they may want to abandon the interview before it finishes.

#### **4.6 QUALITY OF THE STUDY**

The issue of quality in qualitative research has been argued about and debated till now in an attempt to reach a consensus on universal quality criteria (Morse et al., 2002). However, a consensus is unlikely to be achieved because there is no unified qualitative research paradigm which can embrace and guide a whole range of qualitative studies (Rolfe, 2006). Bearing in mind that ‘philosophical underpinnings or theoretical orientations and special purposes for qualitative inquiry will generate different criteria for judging quality and credibility’ (Patton, 1999, p.1189), a diversity of quality criteria are warranted. In light of the methodology underpinning this research, four criteria: ‘credibility, originality, resonance and usefulness’, as proposed by Charmaz (2006), were used to evaluate the ‘interpretive sufficiency’ of the developed core category for this study.

##### **4.6.1 Credibility**

Credibility is the criterion to evaluate whether the findings of qualitative research represent a credible and believable interpretation of the data drawn from the perspectives of the participants in the research (Charmaz, 2006). It entails both the quality of the research process and confirmation of the research findings from the study subjects (Bryman, 2008).

In this study credibility was addressed in four ways. Firstly, to allow the reader to evaluate the credibility of the study, research methods and processes were discussed in a detailed manner early in this chapter. By means of constant comparison, the credibility of emergent meanings and concepts was constantly checked through a coding process, which was fully illustrated in section 4.4. Secondly, theoretical sampling methods enhanced the credibility of the study via self-correction (Charmaz, 2002), which identifies gaps from the developed categories, follows the theoretical hints for

further sampling and finally saturates these categories (Strauss and Corbin, 1998). For example, in light of the developed initial categories ‘workload’, ‘understaffing’ and ‘nursing tasks’, the study recruited a nurse who holds managerial posts, which has added an additional perspective on the nursing experience and the context where nursing care delivery took place. This different data source also provided richer and more comprehensive data to achieve deeper insight into the contextual factors that influence nurses’ responses to ethical issues in practice. The in-depth interviews enabled a more complete understanding of the subject under study.

Thirdly, an independent audit was used to support the trustworthiness of the data. The analysis was discussed with my academic supervisors throughout the research. These discussions added great insights and offered different views to the development of the theoretical categories and final core category. Fourthly, Strauss and Corbin (1998) have recommended that the grounded theory researcher is expected to possess qualities including ‘appropriateness, credibility, intuitiveness, receptivity and sensitivity’. As discussed in section 3.4.1, my position as nurse lecturer and the knowledge gained from my experiences of teaching the subject of ethics, as well as working in a general ward were found to increase these qualities for me as a researcher to undertake grounded theory. In the meantime, in order to retain openness to the data, research memos were used to help me reflect on my background assumptions and their interactions with the data.

#### **4.6.2 Originality**

Originality, according to Charmaz (2006), refers to an assessment of the originality in research findings, including the new insights of the categories, new conceptual frameworks, and the social and theoretical significance of the research. Originality in this study was evaluated by a return to the literature to compare the research findings with the existing knowledge in the field at the latter stage of the research. The conclusions from these comparisons are presented in the discussions within each

findings chapter from chapter five to eight, and in the conclusive discussion chapter (chapter nine).

#### **4.6.3 Resonance**

The use of resonance here is similar to conformability; that is to measure how well the developed core category can “speak specifically for the population from which it was derived and to apply back to them” (Strauss and Corbin, 1998, p. 267). The resonance of the developed core category was tested by being presented to a wider audience. This was done via formal presentations at several conferences, where nursing audiences from Brunei and other countries found more or less a ‘fit’ of the core category to what they had experienced within their own settings.

#### **4.6.4 Usefulness**

Usefulness is an evaluation of the practical significance of the research findings and the direction for further studies (Charmaz, 2006). To evaluate the usefulness of the final findings, the practical significance of the research and the recommendations for further studies are addressed in chapter ten.

### **4.7 LIMITATIONS OF THE STUDY**

To secure research quality, the study has been designed and processed in careful consideration of research inquiry under agreement from, and discussion with, my academic supervisors. However, considering the time and resource constraints for a doctoral project, the limitations of the study need to be recognised.

In qualitative research the researcher is the main research instrument of data collection and analysis; thus the research model has been criticised as ‘too subjective’ (Bryman, 2008, p. 391). The criticism is concerned that qualitative research often initiates ‘in a relatively open-ended way’ and gradually narrows down the research focus, without sufficient clues to the audiences (Bryman, 2008, p. 391). However, for a grounded theory approach, the theoretical sampling method and the relatively structured coding

procedure can ensure that the research orientation is directed by the theoretical thread grounded in the participants' perspectives. Nonetheless, considering I was the only researcher to conduct this study, researcher bias could be seen as an underlying disadvantage. In order to reduce this potential limitation, various forms of triangulation have been incorporated into this study (Bryman, 2008) by bringing in different data resources, comparing findings with existing literature, and using an independent audit, as detailed in section 4.6.

Meanwhile, the recruitment procedure might also impact upon the data in that some of the participants, whom I knew before, may have felt obligated to participate in the study, others may have felt authoritative pressure from their nursing superiors, whilst the participants who were recruited from the relevant nursing departments may be pressured to participate in the study because of the absent or limited availability of other officers who can represent the departments. Additionally, my educational background in nursing studies, vocational background as a nursing ethics lecturer, as well as past experiences of working as a nurse and supervising students in practice, brought some challenges to the current grounded theory study. Nevertheless, my close relationship with the research area has also increased my awareness of the potential impacts that my assumptions could have on the research process. In this case, reflexivity throughout the research process was conducted, as discussed in section 3.4.

Lastly, as an understanding of ethical dimensions and issues in practice, is the main purpose of this study, I only invited local nurses to participate. In future studies, recruiting expatriate nurses (particularly the expatriate assistant nurses) could extend the dimension of knowledge by elaborating on the power dynamics and professional boundary management amongst these health professionals. Also, identifying the impact of such social interactions on the process of understanding and responding to ethical dimensions could provide helpful insights into nursing behaviour.



#### **4.8 SUMMARY**

Following Charmaz's (2002, 2006) version of grounded theory, based on the basic grounded theory practice guideline, data collection and analysis were outlined including how 'negotiating ethical responsibility' was identified as the core category. Reflexivity, ethical considerations, quality and limitations of the study have been discussed in order to substantiate the rigour of the research. In chapter five to eight, the six refined categories that build up the developed of a core category for this study are elaborated, together with evidence from the raw data. Each category is also discussed in the subsequent chapters by drawing on the relevant literature

## **CHAPTER FIVE NURSES AT WORK**

To begin understanding how nurses perceived difficulties in a work setting, it is worth looking at the way nurses understand their nursing work, which consists of nursing care delivery, nursing tasks and scope of practice. It is also worth investigating how ward environment issues, such as understaffing, workload and support contribute to the ethical dimension in their nursing practice. This focus provides a useful starting point for this thesis, since ethical dimensions are said to be embedded in the nurses' working domain.

### **5.1 NURSING WORK**

#### **5.1.1 Nursing care delivery**

Based on data from the interviews, the wards generally practised two types of nursing care delivery models: the total patient care model and the functional model, which is overlapping. The nursing care delivery model is a system for organising and delivering nursing care to clients and their families, and it therefore represents both the structural and contextual elements of nursing practice (Fowler et al., 2006).

In the total patient care model, the nurses were assigned to a group of patients according to the ward bay. Operating in this care delivery model, the staff nurse is responsible for the total care of the patient during the nurse's working shift; in planning for and providing care for the assigned patient. The assigned nurse, also commonly termed as a 'bay nurse' is generally responsible for caring for a maximum number of six patients on each bay for the whole shift. The staff nurse usually needs support from the assistant nurse, who acts as a runner and is usually involved in addressing and providing a basic level of care. This assignment of care however is changed in the afternoon and night duty, when both the staff nurse and assistant nurse are given similar responsibilities because of the small number of nurses available.

The impact on this model on the ward varies. The majority of participants expressed that they are happy when they are ‘in control’ of patient care. *Normah* reflects on her experience as a bay nurse:

*I like bay nursing because you tend to know your patient well. (Normah)*

Such a sense of control is viewed by many participants as central. *Fauziah* for example says:

*I get to know all six of them. When I follow the medical round, it's good to be able to share with the doctors something about the patients' needs or requests. It's a nice feeling. (Fauziah)*

*Normah* further elaborated that the workload of having to care for a maximum of six patients can be demanding, since each patient has their own nursing needs, and therefore in order to ensure such needs are met and tasks are completed, the functional model is integrated within the total patient care model. It is a task-oriented method of service, wherein a particular nursing function is assigned to each staff member. Functional nursing, sometimes known as task-oriented nursing, came about during the expansion of hospital systems in the 1940s, to support and enable the introduction of less-skilled auxiliary staff to deal with staffing shortages (Fairbrother et al., 2010). The focus is on dividing specific tasks among a variety of health-care staff, based on their level of knowledge and the complexity of the assignment (Tiedeman and Lookinland, 2004).

The ward manager or nurse in-charge usually assigns the tasks to each member staff. For example, three staff will be assigned as bay nurses who are responsible to perform both basic nursing care and technical care of patients, such as taking patient blood and insertion of intravenous (IV) cannula. Another role is a basic care nurse who addresses the basic needs of patients, such as giving bed baths, taking vital signs and changing all surgical dressings. Also there is a medication nurse, who is responsible for administering medicine to all patients in the ward.

Going back to the total patient care model, whilst majority of participants such as *Ramlah*, indicated that they enjoy the sense of control in knowing the patient, that outcome is only made possible if there is an existence of teamwork in place. *Normah* points out that:

*Bay nursing is good, only if there is teamwork; helping each other out, and sharing each other's workload. If I were to do all the tasks on my own, it can be stressful and exhausting. (Normah)*

According to information from the interviews, teamwork amongst nurses is inconsistently practised, although it is important. *Daud*, a staff nurse, reiterates the same feeling. According to him, the 'workload is far more organised' if there is a central person responsible for allocating care duties. Thus the bay nurse can address other aspects of patient care. *Daud* reflects on his account when he was transferred to another ward, where each individual nurse is to only look after each bay, without any support from an assistant nurse. He was rather overwhelmed with the chaotic conditions:

*They can't finish doing the vital signs. Not even the fluid chart. They work for the doctors, and not with the doctors. These nurses were far more concerned if the doctors questioned the reasons they can't finish the task given. We can't focus on our job since there are so many orders from doctors. (Daud)*

*Daud* identifies the inability to complete the tasks is because the assigned nurse is taking full responsibility to look after the patient's needs as a whole. This includes following doctor's round, addressing patient's basic care needs, completing the doctor's orders, transferring patient for referral, taking blood and writing the nursing report. The increasing number of tasks was also overwhelming for other participants too, particularly when there is difficulty in obtaining help from the assistant nurse. This situation resulted in some participants having no choice but to work on their own.

*Normah*, a staff nurse, observed the operation of this functional care delivery model and states:

*We won't stop until all work is done. I am not so sure why. But we are often being "probed". We will be questioned if we have not completed the tasks. We are nurses; they expect the nurses to finish the jobs. (Normah)*

In her reflections on the need to complete the task, *Normah* described the pressure of completing the task, without any clear reason for it. The constant act of being probed and questioned over the tasks made her determined to complete the task if she possibly could. She related that the duty was to complete the job, as it is the expectation placed on them by the doctor and their nurse colleagues.

When they are under pressure to complete a task, there is a tendency for the nurse to violate patient care. For example, the minimal emphasis on observing and taking a patient's vital signs, as many participants termed this activity as routine and 'least important', which caused occasional and inconsistent observations to be made. Furthermore, the nurses verbalised that making accurate observations is time-consuming. Burroughs and Hoffbrand (1990) identify that the two barriers to carrying out the observation are the ingrained belief of many nurses in the minimal value of routine observations. The authors also commented on the failure of doctors to participate actively with nurses in determining the observations needed in individual patients, what action needs taking in the light of agreed/observed deviations, and when to reduce or stop making the observations.

The ward environment is made worse when there are emergency situations or when a patient's condition deteriorates. As a result, some of the deterioration goes unnoticed, which may result in the patients suffering, in an extreme case, from cardiac arrest. This was shared by a number of participants such as *Sarimah*, who described the horror on finding a patient's rapid deterioration:

*The patient was okay when I started the shift. Nothing unusual. The next minute, patient had arrested. (Sarimah)*

The British Columbia Nurses' Union published a 'Position Statement' on nursing workload and patient safety in March, 2015. The report suggests that one of the most useful indicators of excessive nursing workload, and its impact on patient safety, is 'Failure to Rescue' (FTR). It is suggested that nurses play a crucial role in monitoring

patient progress, since they are usually the first to encounter early signs of a patient's deterioration. McKee and colleagues (1999) advise that overworked nurses are less able to provide the close monitoring required for safe care. Therefore FTR will help to measure the healthcare system's ability to respond to complications that have arisen while patients are admitted to hospital.

The pressure of having to complete the task at hand was echoed by almost all participants except one. *Halimah*, an assistant nurse, describes that it is still possible to complete the task that was left undone if the ward is busy:

*Both morning and afternoon shifts are busy. Whatever is not done in the morning, will be done in the afternoon. For example, the wound dressing. We don't mind doing them since it is impossible to complete everything in the morning.*  
(Halimah)

*Halimah* shared her own understanding that not all tasks can be completed in a shift. As a nurse, she feels that nurses must support each other in completing the tasks. The definition of 'missed care' is described differently in the literature. In a study by Ball et al. (2012), most nurses reported the missed care related to issues such as comforting or talking with patients, educating patients and updating nursing care plans. The situation is different in this study where the issue of missed care is only concerned with medical/technical matters relevant to the patient, and not necessarily about the patient as an individual; an approach informed by the holistic view of caring.

In contrast to the critique of the functional model, whereby it contributes to fragmentation, lower quality of care and poor patient satisfaction (Duffield et al., 2010), the nurses in this study described that this task-oriented model is relatively invaluable in completing the necessary care and in addressing patients' needs, although it may limit the communication with the patient and others in the ward. As a result "things get done" and nurses generally express satisfaction and relief that the shift ended well. It is however not clear to what extent this model is being implemented in reliable or consistent ways (Minnick et al., 2007). Nor is it clear how effective these models are

in organising and producing quality nursing care (Lookinland et al., 2005). Rowden (1984, p. 220) shared his concern:

*Allocation of tasks leads to fragmentation of care and moves the nurse away from the patient as she becomes more experienced.*

This is reflected in the interviews, whereby the basic care is usually assigned to assistant nurses and junior nurses, whilst more experienced nurses are given the responsibility to handle and manage what they perceived as complicated technical care.

### **5.1.2 Nursing tasks**

Nursing tasks are usually described by the roles given to them: ward-in-charge, medication nurse, basic care and bay nurse.

#### **5.1.2.1 Ward- in-charge**

First is the ward-in-charge. Whether the ward adopts a functional care model and/or total patient care model, the in-charge nurse is responsible for coordinating the work of others through the process of delegation. None of the participants shared any positive remarks on adopting the role. *Normah, Rosmah and Ramlah* found that the pressure of being an in-charge nurse is high. *Ramlah*, a staff nurse reflected her own experience of being an in-charge:

*It is so scary. Hopefully they can follow my order (laughing). I just wish they will follow my order. If I received the admission or transfer from emergency, I have to check the blood pressure. I have to ask the senior even though I am in charge, because I can't make my own decision. If something went wrong, I will be blamed. (Ramlah)*

Although *Ramlah* demonstrated her commitment to ensure the responsibility is achieved, her uncertain view of 'follow my order' is not happily accepted by the majority of participants. The 'order' itself symbolises 'power' in the giving of orders to the nurses. There is however a consistent consensus amongst the participants that the actual role of nurse in-charge is often misunderstood; where the in-charge runs the management of the ward shift, but must also perform hands-on care.

The absence of 'hands-on' created dissatisfaction amongst the participants. *Fatimah* described the role of ward in-charge as follows:

*Despite being an in-charge, she needs to help around. Being an in-charge does not mean that she just sits on the nurses' station. We have received complaints from a number of nurses (Fatimah)*

The expectation that nurses have regarding the nurse in-charge suggests that the ward is busy and therefore everyone should contribute to complete the tasks. *Fatimah* admits that the role of in-charge is the coordination of care; however it should not prevent them from participating in hands-on care:

*The role is, responsible of the ward, but even though that is the case, she has to help where there is heavy workload. It doesn't mean she just sits there, doing the writing. She is also responsible to counter-check the medication given to the patients. (Fatimah)*

As the interviews progressed, this misunderstanding about the in-charge role appeared to be commonly held by the new nurses, whilst the experienced nurses verbalised their own participation in giving hands-on care. Such detached involvement can be explained by several factors. *Rosnah* for example describes:

*As an in-charge, I need to communicate with the doctor, the nurses, patients and family. It is stressful. In that continuous communication, there's always requests, asking this and asking that. Sometimes it is better that I just stay at the station, minding my own work. (Rosnah)*

*Rosnah* reflected her time being a newly qualified nurse where she finds it difficult to having a continuous communication with others in the ward. In the communication, the requests made can be an additional pressure for the in-charge. For *Sarimah*, the difficulty of being an in-charge is having to be able to make decisions quickly, particularly when she became a point of reference for everyone during the shift. She finds this can be a source of stress for her:

*When the doctors ask me, they want an instant answer. How is that possible to know all 28 patients? I need time to read on the nursing note. Others will not understand that. All they see me doing is sitting at the station. (Sarimah)*



There are however nurses who reported the performing of hands-on care whilst being an in-charge. Yet the role of in-charge proves to be a challenge for the inexperienced nurses to delegate the workload and gets the tasks completed. Omar, a staff nurse, recalled his experience when he first started working as in-charge:

*The problem was getting the senior assistant nurse to get involved. Don't get me wrong, these nurses are good, but what happen to me, they don't listen. Some of them can be quite selective in doing the tasks. For example, they said they are old and have poor eyesight, and hence they won't do the D'stix. (Omar)*

This kind of situation was confronted by many nurses and made the shift harder, particularly in a busy ward. For example, *Ramlah* speaks of her difficulty:

*Some of these nurses prefer to be in the kitchen. Enjoying their hi-tea. I have to constantly remind them about taking the vital signs and other tasks. I feel like I am their personal secretary (Ramlah)*

In order to get the tasks completed, a number of strategies have been employed. Omar, for example, had been advised by another experienced nurse that he must make the attempt to 'win the nurse's heart' first by getting the nurse on his side. Only through this strategy will he be able to get the work done accordingly. He expressed frustration that he had to behave as such, and raised the point that 'the assistant nurses are paid to do the job'; and he preferred to complete the task on his own. A similar problem was also shared by an experienced in-charge nurse. *Junaidah* however utilised an assertive communication and participated in the hands-on care herself, as a role model, and was not simply directing the assistant nurses to do the caring.

The overall responsibility of being in-charge is perhaps what makes the role a challenge. Participants highlight that in-charge nurses are accountable for the decisions and tasks they have delegated. The majority of participants described the need to ensure staff members complete the tasks assigned to them. *Sanisah*, a staff nurse, described her habit of keeping track of whether the allocated tasks are being carried out by the nurses working in the shift. She stated:

*It is not really reminding them, because they should know their responsibility. I believe that as an in-charge, I have work together with the staff. Hands-on by the in-charge is a must and not simply giving orders (Sanisah)*

According to *Sanisah*, when workloads are not completed accordingly, she would investigate to find out the reason for this. For her, nurses must learn to set priorities in their work. Prioritisation of patient care by nurses was discussed in conjunction with time management. It became apparent that some of the nurses cannot completely rely on nursing colleagues to complete the delegated tasks, which posed an interesting question of trust amongst the nurses.

#### **5.1.2.2 Administration of medicine**

The administration of medicine is usually performed by an assigned nurse called the ‘medication nurse’. Before the introduction of new policy, both staff nurses and assistant nurses can administer the medicine. In more recent years however, the policy changed whereby only a staff nurse is allowed to perform the procedure. This means that the medication nurse’s role is generally assigned to staff nurses. As a medication nurse for the whole shift, they are expected to help in any way possible once they have completed the medication round. However there are nurses who are not keen to help other nurses with other nursing care.

*Normah*, a staff nurse, said that in her ward, some of these medication nurses “just want to focus on the meds (medicine)” despite the ward being extremely busy. This attitude creates dissatisfaction amongst the nurses. *Normah* believes that, given the busy ward, there is a need to help each other in the ward, and not just focus on the assigned role. This was clearly in contrast with the literature, where it was suggested nurses need to concentrate on the preparation and administration of medicines. Interruption of the nurse at the time of medication administration most likely contributes to medication error (Westbrook et al., 2010) whereby during these activities, any interruptions may lead to cognitive failures among nurses in relation to working memory and attentiveness. Meanwhile with increased workloads linked to understaffing, the ‘medication’ role will often be performed by only one nurse. This clearly goes against

the new policy, which directs the nurses to ‘double-check’ when administering the medicine. *Maimunah* explains:

*There should be two nurses doing the medication, and one of them must be a staff nurse. However, this can be difficult to achieve. At times, when everyone else is caught up with urgent matters, the nurse would carry on and give the meds. (Maimunah)*

The issue of double-checking was mentioned in the interviews; many nurses feel the rule is impossible to follow, and often unnecessary from a staffing perspective. This suggests an area of potential and real conflict within nursing, as some nurses revealed that at times, they have to skip double-checks due to time constraints and understaffing. Double-checking policies are commonly used as a strategy to ensure medication safety. Two literature sources, O’Shea (1999) and Armitage and Knapman (2003), offer somewhat conflicting information whereby the latter demonstrated that following double-checking policies did not necessarily prevent errors. In the former source, failure to adhere to policies and procedures was associated with errors. In a recent study by Hewitt and colleagues (2015), they examined front line health care practitioners’ conceptualisation of double checking. They found that double checking is loosely defined, embracing double checking that can be referred to practitioners looking over their own work, or double checking with a peer.

#### **5.1.2.3 Basic care**

This nursing task consists of performing basic care needs of patients, ranging from assisting a patient with a bed bath to emptying a urine bag. There is, however, a divided view of who is supposed to be providing basic care for patients and this will be discussed later.

#### **5.1.2.4 Bay nurse**

As discussed earlier, the bay nurse is responsible for giving total care to the patient throughout the shift. The care is divided into two types: technical care which involves the day-to-day tasks of a nurse such as taking blood samples and pressures and doing nursing reports. The tasks so far have been presented. Next, the concerns surrounding

the scope of practice of the nurses shall be presented. It is common practice for a nurse to be involved in carrying out many tasks. Whilst assistant nurses are often delegated to focus solely on delivering basic nursing care, there are times when they have to undertake all four nursing roles. This obligation creates concerns surrounding the scope of practice of the nurses, as outlined in the following section.

### **5.1.3 Job description**

Irrespective of the care delivery model being utilised in the ward, there remains a dire need for a nurse to complete the designated tasks before the shift ends. This expectation results in increasing pressure on nurses and, in turn, results in some nurses having to work beyond what they are supposed to be doing. The concern over task boundaries tends to focus on two areas: first, doing what the nurses perceived as medical tasks and secondly, doing ‘someone else’s job’.

Several of the participants such as *Rafidah and Omar* asserted that some of the ‘skills’ they are asked to perform are simply not their job. These skills range from performing invasive procedures, such as taking arterial blood gases to removing the femoral catheter. This demand resulted in the nurses quickly refusing to do the tasks, and justifying their reluctance with: “that’s not my job”. This is despite the medical doctor who repeatedly suggested “you should learn this”. These nurses assert that “If anything happens (goes wrong), that’s a problem for us”.

*Rafidah* strongly expressed concern about the potential ramifications of their actions, should they proceed in undertaking the activities. According to her, she has learnt from previous encounters where she was fully or partially blamed for agreeing to something that she did not ‘feel’ was within her role. Therefore, she felt that it is far better to say ‘no’, than to take the risk and be blamed if things turn out badly. *Latifah and Zaitun* described a similar incident, whereby when things did go wrong, the doctors would find fault amongst the nurses; ever since that, it has been difficult to trust the doctors and to obtain the nurses who are willing to give cooperation.

Whilst *Azean* welcomes the nurses ability to be able to carry out what she perceived as medical tasks, she shared similar worries that nurses are too caught up in doing everyone else's jobs. *Azean* stressed:

*Whilst such medical tasks assist in patient care, nursing care is not merely the technical care. Instead, we are meant to care for patients wholly, psychological, physical, and all that. (Azean)*

However, a number of senior ranking nurses, such as *Saloma and Azean*, were certain that such practice have started in the old days, when “nurses are known as all-rounders”.

When asked to explain what *Azean* meant by that, she replied:

*It has been always been like this. We do all sort of things. We keep the ward running, no matter how difficult. It can be stressful, but we manage somehow. (Azean)*

Kalisch and Aebersold (2010) described the way nurses were being interrupted when they multitasked. Based on the observations they made, nurses were interrupted 10 times per hour, or 1 interruption every 6 minutes. The researchers found that these nurses experienced a high level of discontinuity in the execution of their work. While the nurses manage interruptions and multitasking well, the potential for errors is however present, and strategies to decrease interruptions are needed.

*Fatimah* on the other hand, commented that there are pro and cons on Bruneian nurses' perceptions of their roles as multi-taskers. She recognised that these nurses are multi-tasking because of manpower issues; however, she stressed:

*They just have to be very careful when they multitask that it doesn't jeopardize patient's safety in one way or another. (Fatimah)*

Nonetheless, *Fatimah* recalled an experience in Singapore, where the Singapore nurses were relatively impressed with the Bruneian nurses' ability to do “advanced skills”. This gives her a sense of pride that nurses in Brunei are skilful.

Secondly, there is concern about the scope of duties and abilities between the staff nurses and assistant nurses. Generally the staff nurses perceived that there is no major difference in scope between them and the assistants. The subject of whether or not assistant nurses can administer medicine became a topic of interest for many of the participants. *Daud*, for example was not happy with the medication policy, that restricted assistant nurses from undertaking preparation and administration of medicine and thus, the task is limited to double-checking only. He said:

*Although they (Filipino nurses) are assistant nurses, they are also qualified with degree. I don't understand. There are assistant nurses who become ward in-charge, do reports and many others. Yet they are not allowed to prepare and administer medicine. (Daud)*

*Ramli*, an experienced assistant nurse, called for written standardised job descriptions for the position of assistant nurse. He said so far, he knows the tasks based on the information given by the ward manager, and generally it is “what the nurses have been doing in the past”. He feels that they need to be notified via the standardised job description, and not on a verbal basis. He continued:

*If we have that, it is easier to answer if there are enquiries from the general public. At the moment, we will just keep guessing! (Ramli)*

The majority of the participants indicated that that they were not clear about what can and cannot be done, in terms of their duties. Many still believe that qualified nurses are expected to know how to do almost every skill and are competent to perform the task given. *Saloma* echo this concern:

*By right, there should be a clear job description for everyone; the nurse in-charge should be doing slightly different responsibilities, as should the staff nurses, the assistant nurses. These are not clear yet. (Saloma)*

With this lack of job descriptions, the participants expressed their dissatisfaction when asked to do what they perceived as beyond their role. This confusion was identified by Eagar et al. (2010) who wondered if the conflict surrounding the scope of practice in nursing was a new war or perhaps just the old same battle. The confusion, they suggest,

may lead to conflict, interprofessional rivalry, bullying and this will potentially reduce quality of patient care.

This lack of, or unclear, job description led many of the participants to see themselves as doing multi-task duties. This popular notion was echoed when participants were asked to first describe the role of a nurse. A number of participants stated that “nurses are basically doing everything” and “doing what doctors are doing” or “doing that technician stuff”. *Saloma*, however argued that while some nurses appear to embrace the role happily, it must also be taken into account how much that would restrict the nurses from performing their nursing care. She said:

*Nurses should not focus on the technical stuff, technician's job, doing store man's job, doing certain inventories and all that. (Saloma)*

*Saloma* gave a commonly quoted example procedure that nurses were told for so many years was not their job to do, which is taking blood or, as it is medically known, venepuncture. She admits that it was not supposed to be the nurses' job to do, rather it is the lab technicians or the doctors, but nobody else wants to do it. *Saloma* claimed that if the nurses do not take the samples, patients will suffer; thus this extra duty may result in the core business of a nurse, which is caring for patients, being most often left behind. This can be seen because so much time is spent in preparing the blood form, doing the procedure itself, making sure it reaches the lab, and ‘tracing’ the results on the computer. In fact, the blood sampling process appears to have become one of the top agendas mentioned during the nurse handover. According to *Azean*, this has been going on for so many years and she admits that the nurse's role has been taken for granted. Over the years, she said, since the task itself is not doing any harm to patients, gradually nurses assume such roles, as they are seen as being able to do them. However, the issue of understaffing has now become a major concern amongst the nurses.

Despite the feeling of displeasure of working outside their scope, the nurses generally accepted that responsibility as a professional responsibility and professional commitment. There were a number of nurses who felt that they had no choice but to adjust their roles when they feel that a task needs to be done. This 'giving in', for them, is justified because it is for the benefit of the patients. The new nurses exhibited far more enthusiasm to 'giving it a go' for the sake of seeking for the experience of doing the skill. The assistant nurses are generally far more prepared to work beyond the perceived scope of their roles. This topic will be further presented in section 5.2.1

In responding to the lack of clear definitions of professional scope, the International Council of Nurses (1998, p. 26), states that:

*ICN's clear preference, and therefore its strong recommendation, is that legislation adopt a flexible approach to 'scope of practice' issues. ICN recognises and accepts that benefits in service delivery can result from overlapping scopes of practice among different health professions and that a dynamic approach to professional practice will enable greater public service.*

Pyne (2004, p. 94) however contends that:

*Whilst individual nurses must develop their capacity to meet new challenges, the organizations that bear the responsibility for regulation have responsibilities. While it is absolutely right for them to help set out the platform for professional practice through published codes, guidelines and standards documents, they fail those same people completely if they are silent about the broad areas of health policy and the context in which nurses have to practice. Whether they are, in effect, an arm of a government health department, or a separate organization charged in law with regulatory responsibilities, it is essential that they engage at a high level in the sort dialogue that makes clear the realities of the context of professional practice.*

A similar view was mentioned by some of the participants, whereby there is a strong need for nurses to sit down in a ward meeting, and talk about nursing and nurses.

*Sarimah*, being amongst the youngest participant states that:

*Let's have a meeting amongst us nurses. A meeting where all of us can sit and talk about the challenges facing us in the ward. No fancy or serious issue. Perhaps how best to promote respect for each other, work together and find ways to make the place an enjoyable place to work (Sarimah)*

This indicates a strong need for nurses to have a continuous dialogue amongst themselves to discuss the perceived and actual concerns that are facing nurses in their



day-to-day practice. This has been voiced by the participants, where the ward manager has an important role in improving the nursing state in the country.

## **5.2 WARD ENVIRONMENT**

### **5.2.1 Understaffing**

The ward staff generally consists of four nurses during the morning shift, three nurses in the afternoon, and a minimum of two in the night. The understaffing was felt when participants described the shift. *Normah*, shared her own experience:

*We are lucky if we have the ward manager or deputy ward manager around. They can help us. I think that there should be a minimum of five nurses in the morning and four in the afternoon. Having three nurses at night is truly a blessing.*  
(*Normah*)

In many of the situations shared by the nurses, one striking point materialised: the manner in which the majority of the nurses first suggest that they have been managing ill patients without any problems, even when there are only two of them working during the shift. As they elaborate on their experiences, it becomes clear that such a feeling of ‘managing well’ took place only after a crisis, such as cardiac arrest. As described by some of the participants such as *Junaidah*, many problems seem to occur towards the end of the day when the number of nurses is few and the support only comes from the sister or doctor on call. There is some evidence, although not strong, to suggest the impact of nurse staffing levels on failure to rescue (death within 30 days among patients who had complications) and mortality. An American study by Aiken and colleagues (2008) found that each additional patient per nurse was associated with a seven percent increase in the likelihood of mortality within thirty-days of admission and in the likelihood of failure to rescue. Similar accounts were shared by the participants regarding the above statement. With only two or three nurses working during the shift, several nurses such as *Ramli and Mariani* revealed their feelings of being overwhelmed with the already staggering workload in the ward; having just one or two ill patients made their job even more challenging. The feeling caused the nurses

to “lose focus” in trying to address the needs of the ill patients and the rest of the patients in the ward.

When I asked *Samsudin*, a staff nurse about his experience of working with only one other nurse in the ward, he replied:

*If we were to think logically, it's not possible, you wouldn't manage, but we just hope for the best. (Samsudin)*

*Samsudin* recalled one afternoon when there were only two of them and a senior nurse who was working office hours. There were more than about 15 patients and the first nurse attended the ill patient with the doctor, while he had to sort out the relevant documents for a patient's hospital discharge. There had been no clerk for many years. He described that afternoon as racing against time; not only did he need to ensure that the paperwork and the patient's medicine were ready from the pharmacy (which closed at 4.30 p.m.), but he also had to make sure that procedures such as taking vital signs, glucose monitoring test and patient's insulin were administered before dinner time. Around 5 p.m., he was left all by himself, as the first nurse had to transfer the ill patient to another hospital and the senior nurse left at 4.30 p.m. Then, the sister on-call came around to do the ward round, and only asked whether he was busy. He was rather stunned and did not know what to say. He just wished that the sister on-call had appreciated what had happened by seeing him running here and there. It was only around 7.30 p.m. that the other nurse returned to the ward. Towards the end of the interview, he said:

*You are dealing with human beings. Just imagine, in the ward of 20 patients, you are responsible for each and every one of them, right, a patient can suddenly collapse here, and the other collapse there, that's a problem if you are understaffed. And then, even if there is only one unstable patient, it would be extremely busy. I would sometimes hold my bladder until the end of the shift, that means, you don't have time for yourself, you only think about work. (Samsudin)*

As it can be seen from the above account, *Samsudin* was caught up in completing the administrative tasks for the patient, and yet having to balance that with his nursing task. When asked the reason for not saying anything to the sister, he replied:

*She saw me, I was literally on my own. There is no staff. I would expect her to do something about it. But maybe because I think I can manage, that's why I didn't say anything. (Samsudin)*

Indeed, his whole view of 'managing the workload' appeared to be positive in nature; however, when I raised the issue of how his working on his own may compromise patient safety, he began by saying:

*I guess I was lucky at that time. That everyone was fine. (Samsudin)*

As the interviews proceeded, it appeared from the majority of the nurses such as *Mariani, Saadiah, Omar and Faridah* responses that the shortage of staff may also lead to nurses going beyond their roles and competence, as had been discussed earlier on. This 'going beyond' is amongst the biggest concerns shared by these nurses. They realised that some procedures were "something that they are not supposed to do", yet they argued that "at the end of the day, it needs to be done".

In 2013, the National Health Service (NHS) in England produced a document called Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, also known as the Francis report (Francis, 2013). It is an independent public enquiry into appalling standards of care at the stated trust. In the report, Francis highlighted the importance of the nursing skill mix and staffing numbers in relation to standards of care. Commentators such as Hayter (2013) suggest that, despite low staffing never being an excuse for the appalling lack of care described in the Francis report, it was a contributing factor. Curry and colleagues (2005) argue that the better the nurse-patient ratio, and the higher the skill mix, the higher will be the quality of patient care. Hayter further commented that the lack of care is not simply because nurses lack compassion or lack the necessary skills; rather it is because they are overstretched and struggling to provide the rudiments of care to appropriately large groups of patients.

The concerns on the understaffing somehow make certain practices acceptable. A staff nurse will need the assistant nurse to help them with the administration of medicine; however, the assistant nurses have been happy to perform the task all this while,

although some assistant nurses remained hesitant in performing it. *Sanisah*, a staff nurse with several years of working experiences contended that:

*When there are not enough staff nurses during the shift, and we are extremely busy, it is a problem. Some assistant, they will just give the medicine. Indeed it is our job as staff nurse. It is in the new policy. But if we don't ask for help from the assistant nurses, the patients may end up not having their medicine on time. At times, we have to stop what we are doing, to accompany the assistant nurse. (Sanisah)*

*Sanisah* further recalled that at times, there will be two assistant nurses preparing the medicine, which she believes is acceptable since one of them can become “a witness in case something goes wrong” since nobody wants to cover for this staff. *Rafidah* however remains puzzled if the ward manager is aware of the shortage of staff. She argues that whilst everyone is aware of the new policy on the administration of medicine, it is entirely impractical. Meanwhile *Saloma* offers her view:

*At the end of the day, it became a normal practice. What seems wrong in the first place becomes acceptable and justified. (Saloma)*

*Aziz*, a staff nurse for more than a decade, points out:

*Understaffing is the main issue; if you don't have enough manpower, don't talk about incentives, and don't talk about promotion, because you don't have enough manpower to support you. Manpower is important. We can't just do things on our own. (Aziz)*

Commenting on manpower and workload, *Aziz* expressed the view that:

*With only two staff working in a shift, and over twenty patients, we almost do everything. We are doing clerical tasks and the nursing workloads. We do not have time to rest, drink or eat. It is fine during the morning shift since they have more staff, but not the afternoon and night shifts. (Aziz)*

Being an on-call ward ‘sister’ himself, *Aziz* recollected events where he had to ask for help from nurses from another ward when some wards lacked staff. In fact, he had to use whatever resources were available. *Khadijah*, an experienced nurse who fills a managerial role, clarified that such measure compensating strategy, as described by *Aziz*, is no longer practised. To her, in order to achieve the minimum number of nurses in the shift, the ward manager would have been able to identify if the ward requires more nurses working. She declared:

*We will be ringing the ward nurses themselves who are on day off, and see if they are willing to come to work. We always try to get nurses from the same ward since they are familiar with the ward routine and setting. Of course, we will replace their day off. Well this may annoy some of them, but I think generally nurses are fine with this. (Khadijah)*

Rafidah however believes that in view of the current shortages, nurses must be ready to change their attitudes. She asserts that:

*If we feel responsible, we will do the work together. It's very difficult nonetheless because one's behaviour and mind-set is different. (Rafidah)*

The inability to work as a team is a concern expressed by the participants, whereby most of them reported that working as a team has a significant positive impact on the heavy workload and understaffing, particularly on the issue of job satisfaction. Jackson (2005) suggests that job satisfaction is influenced by effective teamwork. Another participant, Saadiyah felt that “nurses must work and support each other”, and this clearly illustrates that, despite the challenges they are facing in the ward, she believes on the old saying, “united we stand, divided we fall”.

### **5.2.2 Workload**

In this study, participants reported that they are experiencing higher workloads than ever before, due to reduced staffing, as addressed in earlier sections above. Such heavy workloads are characterised by the participants as ‘being busy’. Needham’s (1997) definition of nursing workload has gone further to consider all the nursing time required to carry out all the nursing activities (direct and indirect care), in addition to the non-nursing activities. Normah elucidates this through her account:

*Nurses are always busy. We have to attend to patients, the doctors, the referrals and the paperwork. Sometimes we spent a lot of times sitting and reading the nursing process (notes) if the doctor wanted to know something. It is busy here especially after a public holiday and when the doctors give a lot of orders. Morning shift, typical stuff, attend doctor, blood tests to take, bed bath, bed making, vital signs, attend to doctor's orders, carry forward doctor's orders. (Normah)*

*Normah* added that:

*About 40% of our time is spent following the doctor's round, and then carrying out the orders. Some doctors need clarification whether things are done or not so we have to refer to nursing notes. Some doctors only make verbal orders and nothing is written in the clinical notes, especially on specific blood tests. We end up having to ring the doctors, make some clarification. We don't like things to be unfinished or undone. (Normah)*

To some participants such as *Latifah* and *Ramlah*, this increasing workload is best demonstrated with statements such as “you cannot sit, all the time standing, trying to finish the work”. This finding was similar to a study conducted by Silen et al. (2008) on Swedish and Chinese nurses, where amongst all the ethical problems indicated by the nurses was heavy workload. Hunt (2004) however suggests that, when nurses wish to conform to the implicit value of being seen to be doing a good job and to “play the organizational game,” they are said to recognise the importance of “appearing to be busy”, and this is often manifested in this study, whereby nurses’ such as *Sarimah* and *Omar* verbalised their busyness when asked to describe their work.

Heavy workload also affects the time that a nurse allots to various tasks. A heavy nursing workload seems to be related to suboptimal patient care (Needleman and Buerhaus, 2003; Van Saane et al., 2003). According to *Rosnah*, she believes that nurses in the general ward do not have sufficient time to perform a task or tasks that can have a direct effect on patient safety. *Rosnah* gives an example where there are nurses feel the need to deviate from good practice as a time saving technique. *Rafidah*, for example, revealed her experience of being told to cut corners in changing surgical wound dressings in order to save time. The participants recognised that “cutting corners” in routine care is wrong, yet they maintain that such an act does not affect patient safety, and it is not done on a regular basis. In several accounts, participants shared the stories where several years ago, patient medication was prepared early. They justified such practice with three explanations; first, the nurse was just trying to help the next nurse on shift since the ward is hectic; second, proper precautions have been taken to ensure no wrong medicine is administered; and three, the patient gets the medicine despite the

hectic ward conditions, and that matters. However, this justification does not guarantee patient safety; some participants disclosed incidents of wrong drug administration. Maimunah, who holds an administrative position, revealed that medication errors have increased over the last ten years. *Mariam*, a staff nurse, blamed the nurses' attitudes for cutting-corners in their patient care. She stated:

*I have seen that nurses who don't want to spend time with patients, even if they can, they'd rather sit and chat among themselves, busy with their 'Facebook'. (Mariam)*

The heavy workloads were also associated with reduction in the time spent communicating with patients, doctors and nurse colleagues. This is demonstrated by the distance that the nurses have to cover in order for them to focus on their own tasks. On a number of occasions, the participants spoke about their reduced interaction time that they have with the patients. According to the participants, the interaction only occurs during the doctor's round, or when they performed procedure such as checking a patient's vital signs. *Mariani* remarked that:

*It all depends on the shift. If nurses were too busy, the communication is rather restricted to important matters". This means that nurses only select what they view as important for the patient to know. (Mariani)*

*Daud* admitted that the ward can be busy and that some nurses would find it hard to sit and enjoy a quick meal. He said:

*We eat and rest, but we still carry out patient care. And there's paperwork too. Some seems unnecessary. I know some nurses just 'chart down' on the two hourly patient turning, yet it was not actually done. (Daud)*

From the account, *Daud* recognised the heavy nature of the work, but that does not mean that the nurses can devalue the safety and needs of their patients. For *Daud*, safety of the patient takes precedence over the nurse's own needs. Similarly, a number of participants, such as *Daud* and *Rosnah*, were cautious when nurses described their job is stressful. When asked if she thinks nursing in Brunei is stressful, *Rosnah* responded:

*That depends on the ward, especially if there is no teamwork. All the patients need our attention, maybe because the staffing is insufficient. (Rosnah)*



*Rosnah*, on the other, was sceptical when nurses always describe how busy they are, and that they must finish the job. She does not think that this is the case and in a sarcastic mode, she claims that some nurses just want to be seen as busy: a ‘make work’ approach. *Rosnah* strongly believes that nurses must learn to prioritise their tasks. However these observations cannot diminish the impact of the reality facing nurses today. The heavy workloads and the understaffing were two contributing factors that are linked to stress or burnout amongst nurses. Lazarus (1984, p.19), described stress as:

*A particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her wellbeing.*

It is argued that if high stress levels are maintained this could result in burnout. In terms of nursing, stress and burnout can have long standing implications for the nurse regarding their health and job satisfaction: for the employer, employees’ stress can influence turnover and absenteeism. This is illustrated in the stories shared by *Normah* where there has been an increasing concern over the absenteeism amongst the new nurses:

*New nurses are okay initially. Once they are permanent, they become problematic. They are always on sick leave, yet we don’t see the sick leave form. (Normah)*

Several participants such as *Omar and Mariam* described their plan to leave the job in the future. In a number of studies that describe the nurses’ intention to leave their profession, Rudman et al. (2010) longitudinal study, for example, suggests that in Sweden, 10–20% of new graduates have considered leaving the profession. Salminen (2012) study have reported that nearly half (37%) of young registered nurses (under 35 years) working in hospitals described reiterated intention to leave the profession in Finland.

One review of international studies found between 4% and 54% intended to leave the profession (Flinkman et al. 2010). The studies may vary in their definition of ‘intention



to leave', and as a result studies differ significantly in their conclusion of the proportion of nurses intending to leave. The majority of participants in the study however did not see such an option; they had to endure the workload in order to earn money and support their family. This stay decision is particularly understandable if working in the Brunei government sector, as such employees are privileged with a number of benefits, and thus to resign or change career is highly improbable.

Whilst a number of experienced nurses shared their own stories where they have been successfully managing the workload in the past, *Mariam* disliked the comparisons made. *Mariam* states:

*I am not trying to be biased when the seniors kept on saying, nurses today are not like nurses in old days, and I disagree. We kept on defending because; we are from the new generation, right? Well, you cannot compare. Nurses now, I notice, lack giving patient care, but we cannot completely blame them. They tend to support everybody's work, whether they like it or not. (Mariam)*

*Mariam* also disagreed to the comparison made to abroad nurses where they are viewed as far better in addressing actual nursing care. She said:

*We can't compare Brunei nurses to other countries because other countries nurses have people who take blood for them. In this country, nurses are given so much paperwork. Nurses who came back from abroad where they introduce new 'more paper'. As a result, nurses end up doing more report, thus they are lacking in patient care. Paperwork is important; it depends on how you set the paperwork. (Mariam)*

The disagreement put forward by *Mariam* was shared by two participants, where all three had experienced studying abroad. *Mariam* asked for a fair judgment when nurses, particularly the ones holding managerial positions, look at understaffing from a different angle; they should not quickly blame the nurses as unable to manage the workload, or hastily conclude that the nurses have 'attitude problems'. A report Patients Not Paperwork – Bureaucracy Affecting Nurses in the NHS, (NHS, 2012) attempted to examine the issues around the burden of paperwork affecting nurses. The findings of the online survey showed two particularly striking results. The overwhelming majority of nurses, 77.9%, confirmed that not only is paperwork time consuming and difficult

to complete, but also it adds little value to patient care (68.1%). The report further highlighted the issue of 'duplication'. Not only did it erode their primary role as a nurse, certain documents had only minimal value. A study from Ireland conducted by Butler et al. (2006) supported the previous assumption by concluding that increases in the level of non-nursing activities, such as staff and unit management, student supervision and training, answering telephone calls, providing medical supplies, attending staff meetings and system administrative work, will lead to a significant increase in a nurse's workload. Chambliss (1996) discovered that individual nurses and their settings are reciprocally and mutually defining, and that the nurses' moral life is subject to routinisation and conflicting roles. He concluded that the moral behaviour of nurses and others is shaped by their organisational and professional roles and the settings in which they work.

### **5.3 SUMMARY**

The interviews provide a closer look at the real nature of nursing work. The findings of the study indicated that there is a general consensus as to what constitutes the work of nurses, despite the noted absence of a clear statement of job responsibilities for nurses. The findings also indicated that there is a slight differentiation between the work of staff nurses and assistant nurses within the workforce, although a considerable proportion of this work is shared. This sharing results in their roles being rather unclear, redundant and at times, going beyond the nurses' ability to practice safely. As a result, the nurses endeavoured to negotiate such roles and responsibility in making sure that the care provision will be minimally interrupted.

The findings in this chapter also illustrate the ward environment to be influenced by factors related to managerial issues, such as understaffing and heavy workloads. Understanding the nature of nursing work has grown as a result of the constantly evolving healthcare industry (Berry and Curry 2012). There is a need for ward managers to address the workload issue which will, in return, contribute to the promotion and

maintenance of safe practices. This is essential in meeting the demands resulting from the recent rapid changes in the health care paradigm. In the next chapter, the nurses' roles are further challenged as the nurse – doctor relationship is examined.

## CHAPTER SIX

### NURSE AND DOCTOR

In the previous chapter, nurses described their work as nurses. Their descriptions are however, largely influenced by their working relationships with the doctors.

#### 6.1 THE RELATIONSHIP

##### 6.1.1 Working relationships

The working professional relationship that a nurse has with a doctor has a long historical and sociological background. The nurses in this study took a variety of views when asked about the nature of their relationship with doctors. A majority claimed that their relationships with doctors have been much better in recent years; largely as a result of better communication between nurse and doctor. The nurses associated this improvement with the increased presence of local doctors in the hospital setting. Local doctors were said to be more appreciative, not authoritarian and they listened to the nurses. Hence, more than half of the nurses called their relationships with doctors “positive” in more recent years. For example *Rosnah* notes:

*Doctors are still up there, but maybe now it's getting better, since we have more local Bruneian doctors. Things are getting better nowadays. (Rosnah)*

Others believed that positive doctor-nurse relationships tend to involve nurses who display a high level of confidence and possess a great deal of clinical experience. Such levels of confidence can be seen when nurses are able to speak up and are ready to have an honest dialogue with doctors, although the dialogue has to be carried out in a most subtle, gentle, even respectful, manner. Graduate nurses seem to have a better working relationship with doctors; there is, in other words, some feeling amongst nurses that graduates are, in some way, “on a par” with doctors. *Mariani* explains:

*The graduates hold a degree from abroad. There's no difference from the doctors. In a way, they are in a better position to communicate for us. They can challenge the doctors. (Mariani)*

*Junaidah*, a nursing officer who graduated recently, describes her experience:

*I have a good professional relationship with the doctor. I share my view about the patients. I always demonstrate to my staff, how to properly speak or discuss with doctors when there is any conflict or disagreement. There is a way to it. (Junaidah)*

From the above extract, *Junaidah* emphasises the professional relationship with the doctor in terms of her ability to share her views about the patients. She acknowledges the difficulty that some nurses have when interacting with the doctors, but she remains positive that such interaction is possible if it is done in a professional manner.

The second factor that affects the nurse-doctor relationship is that, it seems that extensive work experience is also the key and helps to build a long-standing rapport and trust between professionals. Nurses who have been working for several years tend to be ‘well-versed’ with the way doctors work and communicate, and nurses learn how to get along with them.

Additionally, these points seem to be true as well with the nurses who hold some authority for example, ward managers. For example, a number of participants such as *Junaidah* shared stories about the ward managers that engage in positive relationships with the medical doctors; such relationships then create a positive environment for both nurses and doctors to work together.

The ways in which a nurse perceives his or her relationship with a doctor has a fundamental effect on the overlapping concepts of respect, cooperation and trust. Whilst respect is a fundamental element of any professional relationship, it needs to be earned and demonstrated by nurses. *Fauziah* reflected that, during her time working as a nurse in the early 1990s, doctors were described as authoritarian, which caused the relationship to be labelled as ‘parental’. That situation is different from today, whereby the nurses, particularly the younger ones, have a tendency to challenge or question the doctors’ orders. *Fauziah* continues:

*That would not be something that we ever thought of doing. Not at all. We never go against the doctors. For us, nurses are just nurses. What power do we have? We are only caring for patients, whilst the doctors give orders and we carry it out. (Fauziah)*

What *Fauziah* described here was the professional socialisation that occurred between these two professionals. Obedience was clearly illustrated in the remark “we never go against the doctors”. For *Fauziah*, such obedience is expected since nurses are ‘only nurses’, whose primary concern is caring for the patients, whilst it is a plainly acceptable that doctor’s role is to give orders and thus, nurses are expected to implement those orders. This mind set also reflects the reality at that period, when obedience to a medical doctor, sister or matron seemed to work well in ensuring care is given accordingly. It also echoes the traditional doctor-nurse ‘power’ relationship, whereby the doctor-nurse relationship has been regarded as principally patriarchal (Dingwall and McIntosh, 1978) and as a dominant-subservient relationship (Gamarnikow, 1978). It has been argued that it is impossible to obtain an understanding of the doctor-nurse relationship without an awareness of relationships between men and women in society through time (Carpenter, 1993).

The sexual division of labour within the medical world has been seen as a logical extension of the male-female role-relations in society at large, where women have been expected to possess expressive, emotional, and caring qualities. In the first of the three developmental stages of British nursing, the Nightingale era, the goal was to transform the nurses according to the ideal of the Victorian “good woman” (Carpenter, 1993). Good nursing care was equated with caring for the patient and efficient fulfilment of the doctors’ orders. The “obedience to doctors”, as stated by *Fauziah*, is a good example of where nurses are considered to be a ‘good nurse’ when they obey the doctor’s order. Pyne (1998, p. 90) explains the result of the nursing profession’s distorted traditions, whereby professional mores “though unwritten, appeared to be saying very powerfully that ‘good conduct’ meant being compliant and submissive”. Pyne (1998, p. 90) further notes:

*It is this that has created a scenario in which practitioners, for far too long, pretended that they were coping when they were not, deceived themselves that things were better than they really were, struggled to paper over the cracks, and in the end, let it appear that there was spare capacity in the system where there was not.*

Pyne further suggests that this conduct may have something to do with the ‘obedience culture’ that gripped the nursing profession from its early days, which was epitomised as long ago as 1874 by Florence Lees, in her publication *A Handbook for Ward managers*.

Several years ago a master’s thesis, written by a local nurse, reported the stress experienced by nurses in the country (Damit 2007); it was revealed that one of the main stressors felt by the nurses was the nurse-doctor relationship. Of over 200 nurses responding to the survey, only 20% reported feeling satisfied with their relationships with doctors; 80% doubted that doctors understood nursing responsibilities. One of the main issues raised in the survey was that nurses were still finding it difficult to create a healthy working relationship with the doctors. What emerged was the description of a rigid hierarchy that positioned doctors firmly in charge of patient care. As a result, both professions have difficulty in making a direct communication with each other, whilst the nurses consistently reported feeling frustrated and dissatisfied with working relationships that devalue their professional worth.

### **6.1.2 Communication**

Going through the research interviews, there is a cynical yet slightly optimistic view amongst the nurses on the manner in which communication by these two professionals takes place. The majority feel that good communication is crucial to establishing and maintaining good working relationships, as well as improving patient safety.

Two of the common responses from the participants, when asked about the communication that they encounter with doctors, were i) that “they don’t listen to us” and ii) “they get angry at nurses”. In many instances, particularly when nurses are new, this ‘being heard’ is seen as important for their further involvement with patient care.

For example, *Mariani* describes the satisfaction she felt when her views were heard and appreciated by the doctors:

*It such a nice feeling when the doctor hears you, listens to your suggestion on patient care. It feels good, to be honest. They appreciate you as a team member. (Mariani)*

The emphasis on the importance of being heard, and being able to share views with the doctors, reflects a widespread confidence amongst the nurses in the importance of working in a team, and not as a mere follower. To them, being heard is also a symbol of being respected. Meanwhile, several participants like *Zaiton and Sarimah* recalled disrespectful behaviour by doctors toward nurses. The evidence for this was episodes of “screaming” and “yelling” from the doctors. This behaviour impacts on the healthcare environment in a negative way, particularly in the manner nurses and doctors interact with each other. *Zaiton* explained that doctors tend to get angry with nurses:

*When they get angry and it is not our fault, we just smile, keep quiet and accept it. We simply listen. I mean, there are times where I feel I want to say what's on my mind, but I tend to just keep quiet. (Zaiton)*

*Samsudin* speculates that the nurses “just tolerate” the incident where a doctor displays anger towards a nurse. But there was also an incident when *Samsudin* saw:

*The nurse was in the middle of receiving patient's report (handover). The doctor came and demanded a nurse to follow her medical round. She got angry and replied inappropriately, asking the doctor to wait until the report finishes. Of course the doctor then got angry. (Samsudin)*

Davis (1990) who compares the nurses' response to negative behaviour by doctors, showing that silence was sometimes the best way to deal with the doctors. This suggests that, in the nurses' eyes at least, some disagreements are not worth fighting over. Davis claims that allegations of nurses' inability to fight for themselves arise because the nurses know that their concerns are neither heard nor understood.

*Ramli*, an assistant nurse, reflects that the need to “keep quiet” is necessary. He shared incidents where nurses “fought back”, and this resulted in them being “outcast and



cautioned” by the nurse superior. *Ramli* claims the doctor involved will seek the ward manager and ask, why the nurse is behaving in such a manner. As a result, the manager blames the nurses. *Ramli* elaborates:

*When you saw your friends being treated that way, whilst she tried to speak out for nurses’ rights, they were being condemned instead. There is no communication with each other in the ward. It is difficult. (Ramli)*

Ignoring the doctor has also been one strategy that nurses utilise when the doctor gets angry with them. *Ramli*, for example, recalled that some doctors are simply “being moody” and this results in the nurses having to ‘take the heat’. This directing of anger at a nurse is “unfair” and “unprofessional”. *Ramli* claims that:

*Some doctors think that they are superior; they are ‘big’, and that they can do anything to the nurses. We know our job, and we don’t need the doctor to tell us what to do. I just simply ignore them. What I can see, most nurses just ignore them. (Ramli)*

For some nurses, ignoring such behaviour is an illustration of protest and sending a message to the doctor that such an attitude is not acceptable. Meanwhile, when asked the reason why some nurses do not mind being “lectured” by a doctor, *Mariam* explains that the nurses “got used to that”. Thus, they exhibit a behaviour where they “can’t be bothered”. *Mariam* admits that she is beginning to adopt such behaviour. She observes:

*I try to do everything at my best, to finish what I can do, try to minimise the complaint from the doctor on the following day the next day. I make sure all the order is complete, the x-ray film is available and many other things. I just get ready, with answers and all that. Nevertheless, if there is something that I failed to know, then I would simply tell them that I don’t know or I will find out. (Mariam)*

This observation reflects a common theme: the nurses’ loyalty and willingness to tolerate a great deal from a doctor with whom they have a long relationship. In some cases, when the nurses voiced their concerns or tried to stand up against any accusation made against them, this is bitterly interpreted by either the doctor or the ward manager and considered too argumentative. Some of the participants further suggested that if one makes too much ‘noise’, the nurse will soon end up being on the black-list or end up being transferred to another ward. But some nurses disagree that such a bold approach to criticism from doctors is the best answer. In Brunei, confrontation

is seen as impolite and undesirable in all circumstances. The participants believe that sometimes it is the way that the nurses answered back to the doctors or superiors, which is wrong and disrespectful. Still, even if it is something to do with nurses' poor communication skills when trying to defend themselves, it does not give the doctors the right to direct their frustration at the nurses. It may well be a relatively common scene, but it is the way such frustration is expressed that is often questionable. Such frustration, said Saadiah, can stem from technical faults, which are beyond the nurses' control, or simply some doctors just get a little impatient to get things done. *Saadiah* was fairly critical with the way some ward managers' deal with this. She explains:

*Some ward managers think that the nurses start the problem, and thus let them solve that on their own. For me, that cannot be the case. The ward manager must play a key role; at least, find the root of the problem. Look after the welfare of your own people. You don't allow the doctors to bully the nurses. There must be reasons when things happen. (Saadiah)*

For *Normah*, she admits that she is not "brave enough" to speak out if she disagree about the decision made by doctors. She recognise that doctors "like to give orders", and "we are the ones who execute them". When I asked *Ramlah*, a staff nurse, whether the medical doctors had ever got angry with her, she said "yes". However, she did not take it personally, instead reflecting that:

*We must ask ourselves, why doctors get angry. We have to find out why. What the doctor wants actually? If we don't understand the orders, then we must see the doctor ourselves. It is important to clarify early, even though we may not like them. (Ramlah)*

This account is sending a strong reminder for *Ramlah* to always clarify any medical orders at the earliest possible opportunity. This act is essential since the root of the problem can be known and hopefully dealt with. *Ramlah* posits that there are times when nurses are not sure of the medical order or doctor's handwriting. Instead of seeking clarification, nurses just make assumptions about the order, or completely 'forget' to fulfil the order (particularly a verbal order).

Several nurses assert that the anger shown by doctors is somehow necessary and justified. *Junaidah*, for example, was adamant that doctors lose their tempers because

some nurses are ignorant about their patients' care plans and needs. She argued that nurses today, when asked about the patients in their respective ward, usually reply "I don't really know", often followed by immature excuses such as "Oh, I just had a day off" or "I just returned from my annual leave" which is utterly appalling. She was perplexed that nurses today lack a sense of curiosity to find out more about their patients. The doctor's response was, "This is your patient, and you should make an effort to know about your patient during handover". *Junaidah* admitted that the doctor was actually teaching her. She learnt that it is difficult for doctors to offer continuous care if the nursing care is fragmented. Nurses, she said, must be able to know about their patients and nursing care, and this is the only way the image of nursing can be improved. Unfortunately, not many would concur. *Junaidah* further claims that when the doctor gets angry with the nurses, the nurses feel defensive and label the doctor as 'being difficult'.

Several nurses such as *Mariani*, *Samsudin* and *Aini* agreed that the doctors' anger was, at times, justified because if the nurses do not know their own "stuff", that perception may make it harder for doctors to respect the nurses' work. Similar to *Junaidah's* view, *Mariam* speculated that the source of anger could be as a result of frustration experienced by the doctors when the nurses appear not to know much about the patient, when asked. *Mariam* explained that when the ward is too busy, the in-charge nurse assigned a runner (not assigned to the patient) as a "back-up". This resulted in the runner being cautioned because the doctor preferred to have the nurse who is in-charge of the patient care. She then speculated that:

*Since then, they seem to hate us. In my opinion, the runner must identify herself as the runner. If they don't tell and just appear not knowing at all about the patient, then it seems reasonable that they are getting lectured. Of course, it is still not professional for a doctor to do that. (Mariam)*

It does seem that communication problems stem from all the factors affecting their interaction, not just power-gender issues, as other studies have concluded (for example, Dingwall and McIntosh, 1978; Savage, 1987). It appears that poor communication

persists as long as nurses view their roles and functions as fundamentally inferior to those of doctors. What should be of concern would be, when nurses are too fearful to share their observations and judgments with the doctors. There was evidence for this inhibition when the participants mentioned about their fear of being ‘blamed’ for the things they say to the doctors. Therefore, to say that doctors do not understand or appreciate the value of nurses’ contribution would be imbalanced. *Mariam*, a staff nurse, held a strong belief on the importance of maintaining professionalism when working with the doctors. She stated:

*I believe our local nurses are relatively vocal in addressing what they think is right. They tend to fight and become defensive at times. But to be able to do that, we must have the knowledge to back us up. Talk as a professional with the doctors. We don't go simply shout back at the doctors. There are boundaries and ways to go about it. (Mariam)*

*Sarimah*, on the other hand, described the good relationship with the doctor, saying:

*We are all the same. There is, of course, communication breakdown between nurses and doctors, and it is everyone's fault. (Sarimah)*

Several participants such as *Ramli* and *Mariam* put a strong emphasis on the view that nurses and doctors are “all the same”. When asked to elaborate, the common response is the similarity in terms of the role of “helping the patient”, but not necessarily similar in term of status and hierarchy. *Mariam*, when asked about communication with doctors, explained:

*We still communicate, on the notion that ‘I am a nurse, and he or she is a doctor’. In this hospital, the relationship is good. We tend to know everybody. The doctor addresses you by name, and not simply ‘nurse’ and it is a nice thing. There are however doctors who are very ego centred. (Mariam)*

*Mariam* reflects the explanation made by another ‘humble doctor’ that doctors from certain parts of the world feel ‘forced’ to hold on to their real or imagined status. She gave an example of an Indian doctor who came to Brunei and who still holds a rigid view of the social classification or hierarchy and their position in it. What is important, for *Mariam* is for nurses to possess good knowledge. She argues that:

*If you have knowledge, the doctors will notice and they won't simply do whatever they want to you. (Mariam)*

The importance of knowledge is acknowledged by most of the research participants, some of whom feel strongly that, only with knowledge, can they win the “battle” against the doctors. Radcliffe (2000) noted in the British Medical Journal that after the 1970s nursing reconstructed itself as an independent profession, and he questions whether such a pursuit of equality was inspired by a belief in the value of nursing or simply by an inferiority complex Radcliffe (2000, p. 1085) further commented:

*Doctors are a simpler breed than nurses. Everyone knows what the doctor's job is. Doctors are the conduits of medical knowledge. They don't have to constantly redefine themselves. Doctors are little more than what science allows them to be. They are a totem. They don't rethink for themselves, they don't need to. This gives them plenty of time and opportunity to redefine nursing. Medicine remains in the ascendancy. The capacity to cure has greater market value than dealing with distress. And frankly so it should. But in the face of that, might not nursing have done better than “if you can't beat them join them”?*

This is further evidence to support Radcliffe's somewhat cynical views amongst the younger nurses, who express enthusiasm to attend nursing and medical lectures; although for them, the knowledge may not be relevant to their practice. Such enthusiasm, according to the nurses, was highly visible amongst the expatriate nurses where they put a greater emphasis and interest on developing their knowledge as part of their professional development. These eager attitudes are in direct contrast to the local nurses, particularly the older ones, who seems “unconcerned” and “lazy”. This view was expressed by several participants, such as *Aini*, who viewed local nurses as being little motivated to attend lectures, except “if they have to”. However, *Normah*, in her sceptical tone describes how:

*Foreign nurses are different. They have to maintain the points so that they can stay and get their contract renewed. Unlike the locals, the points are important but not that important, if you know what I mean. (Normah)*

Not only that, the presence and contributions of the expatriate nurses were viewed as invaluable. *Khadijah*, for example, claims that the presence and teaching of the expatriate nurses helped in so many ways. Of the expatriate nurses in the old days it

was said that, “they know what they are doing”; they were nurses possessing degrees and having vast working experience; hence the teaching tended to be very good, although they appeared authoritarian. She reasoned this as necessary, as their intention was for the well-being of the patients and that nurses must know what they are doing, as patient-care responsibility falls on the individual nurses.

Another area that some nurses appear to resent is the constant need for the nurses to be present during the ward round. For some nurses this is not feasible, particularly when they are occupied with their own patient tasks. *Mariam* described the doctor ward round routine as a possible hassle for the nurses. This begins with the junior doctor making the round first, followed by the senior doctors which can be a problem for nurses to be present, particularly when the nurses are busy with patient care. *Mariam* questioned such practice, in saying “Why can’t they just do one medical round?”

For *Mariam*:

*You see, the nurses have to follow the round. We have different medical teams, right from renal to endocrine. We are literally dead if these two teams come at once. The good thing is that we know the individual doctors. Some teams are fine not to have nurses 'present, whilst for others it is a must. (Mariam)*

*Mariam* emphasised the need for nurses to be present during the redundant ward rounds, although the nurses strongly disagree because it is taking the nurses away from their own nursing tasks. Lees (2013) maintained that the main challenges of nurses to participation in ward rounds are the other duties that are often regarded as competing priorities, such as the medication round, particularly if close to the time for a ward round. Some nurses in this study, however, began to learn the doctor’s preferences and would attempt to make sure the preferences were met. The nurses recognise that this is a daily routine which is of central importance; however, due to shortage of nurses and heavy workloads, they feel that they may not be able to participate in the ward round.

Samsudin clarified this issue by saying that it is common practice that nurses must be present during the medical round for a number of reasons:

*First, is because of the information on patient care. Some doctors make verbal orders. Second, we tend to know more about our patient, than the doctor. Third, when doctor writes an order, we can know more about our patient. It's very important to address the patient as a whole, their feelings, and head to toe assessment. From there, we can know a patient's changes. Unlike before, the report does not reflect much about the patients. Now, the ward manager puts emphasis on patient care in the nursing report. (Samsudin)*

The presence of nurses during the ward round may also be related to the communication incompetency amongst the doctors to speak the local language. This is not a surprise since Brunei still employs a large number of foreign doctors from countries such as India, as well as neighbouring countries such as Malaysia, Burma and Indonesia. Although the doctor is not able to speak the local language, Malay language or Bahasa Melayu, they are expected to acquire the basics to communicate better with their non-English speaking patients. The Ministry of Health offered classes to accommodate such learning needs. It is possible then that the doctor feels reassured that, despite the limitation, they are always able to communicate with the patients via the local nurses. Furthermore, there have been a number of complaints posted in the social media where the general public complain about communication problems where doctors do not speak Malay, and therefore they are not well versed or connected with the non-English speaking patients.

### **6.1.3 Status**

There is a variety views by the participants, when they described the treatment they received from the doctors. Respect is a major issue that is interpreted differently by different people in different contexts. For some of the participants, doctors seem to be allowed to act towards nurses in a manner that is disrespectful and unprofessional, when they attempt to assert their authority and power, as has been illustrated earlier. This view further strengthened the perception amongst doctors that nurses are “subordinate”.

The lack of respect between the doctors and the nurses was a common issue raised by the nurses who participated in this research. *Junaidah* offered her view on why this



situation still exists. According to her, this lack of respect from the doctors may be rooted in the way nurses present themselves, as well as how they perceive themselves. For example, during the ward round, nurses present themselves as passive, and say very little about the care of patients. According to the participants, some prefer to stand there and keep quiet, whilst others feel the need to share their opinions with the doctors. *Saadiyah* explains:

*When the team (doctors) arrives, the nurses would quickly make their way to follow the team, from one patient to another. Their job is to pull the curtain. Some will remain quiet, and just wait for the doctors to order something. But there are also a few nurses who would get involved in the doctor's conversation, telling them about the patient's complaint or response to the treatment given. They don't just stand there. They get involved. (Saadiyah)*

Here *Saadiyah* is describing that the nurses' involvement in what was described as 'a doctor's conversation' is a choice made by the individual nurse. Few nurses are willing to take such initiatives. Meanwhile some participants described the humiliating treatment they received from medical colleagues, which further questions the status of nurses. *Mariam*, for example, describes the humiliation from the doctor's actions:

*There are nurses who don't like doctors because the doctors look down on them. It is true. Sometimes doctors like to humiliate the nurses. They always think of their 'class'. They shout and caution nurses in front of others. They think nurses are stupid. They would ridicule our ability by saying 'oh, so you don't know?' Nurses then become defensive and humiliated. We are not supposed to humiliate people, right? I was once viewed as not knowing anything by the doctor. (Mariam)*

This causes a considerable amount of embarrassment to nurses if they are the focus of, or even a witness to, such public dressing-downs. The nurses "accept", not because they feel it is their fault, but because they feel it is better to "just keep quiet" in order to be seen as "professional". Gal (1991) conducted research on varied forms of cultural expression adopted by women whereby, on the surface, the women may be perceived as silent and inarticulate. However, such behaviour may also be ways of asserting one's own power or resisting that of another. Glenn (2004), on the other hand, suggests that disadvantaged groups often employ 'a rhetoric of silence' as a means of subverting power.



There is a general view that participants talked about the nurses' right to be respected as a nurse. Most disliked the idea of being seen or treated in the role of handmaiden.

*Kalsom* described her own account of such treatment:

*Some doctors are fine. Some make demands, asking the nurse to get the medical notes for them, or the treatment chart. They will be saying 'okay you do this, and do that' but they are not clear what actually they are asking. This usually happens if the doctors disagree with each other's decision; so confusing for us nurses and patients. (Kalsom)*

The sentiment of being the doctor's handmaiden was shared by several nurses like *Latifah*:

*Nurses have to chase after them. It's so annoying. We have to open the medical case note which is right in front of them! It is funny because we have to do that for them. (Latifah)*

*Azean* speculated that the stereotype was a tradition started during the old days, when nurses' were expected to assist the doctors whenever possible in looking after the patients. Such a tradition, she held, has been taking place for many generations. When asked further, she expressed that there is no doubt that Brunei is heavily influenced by the 'Nightingale' system, whereby one of the main virtue in nursing is the virtue of obedience. Sellman (1997) suggests that the demand for obedience reflected a cautious acceptance of male dominance in a hospital environment, which was difficult to displace.

Many blame the ward managers for the image doctors have of nurses. *Mariani* feels that some doctors still regard nurses as ignorant, and this can be partially blamed on the ward managers promulgating a particular attitude. Another nurse, *Aini* recalled that previous sisters would stand up for nurses, and would protect them from criticism from doctors. But these days, the participants thought that ward managers would rather keep quiet and not take responsibility for accusations or mistakes made by their own staff. According to the respondents, when the doctors complain about nurses to ward managers, the sisters seem not to know how to respond, and thus an inaccurate picture of the nurses has been painted. Moreover, some ward managers are not as firm or

as strict as previous sisters have been. Therefore, the nurses express curiosity about whether the ward managers prefer to stay silent, because doing so keeps them out of trouble.

With regard to issues of status and responsibility, some nurses strongly assert “I am only a nurse”. Doctors are seen as the “experts” who, being just that, do not need to justify themselves further, and therefore their accountability is never questioned. At the same time, some nurses claim that they are respected less than doctors because of their academic backgrounds; doctors are all graduates while most nurses have only a general nursing diploma. This generates a lot of resentment amongst nurses, who persistently argue that they do not want to be treated as “maids”, yet their subordinate role perpetuates such perceptions. However, this conclusion contradicts statements made by several participants, such as *Junaidah*, that doctors actually appreciate some non-graduate nurses who demonstrate both competence and increased confidence. The majority of the participants claimed that the difference in educational levels between most nurses, and the doctors with whom they work, will remain the factor that would certainly affect the balance of power. *Azean* suggests that nurses are still feeling ‘inferior’, viewing doctors as being ‘cleverer’ than them.

Many of the participants demonstrated interest in pursuing a degree programme in nursing, but the challenges prove problematic for the nurses to overcome. According to them, unlike the short term courses, a full time degree course, which may take three to four years, is relatively costly for these nurses. In other words, they have no choice but to join a long waiting list before being offered a full in-service scheme covers the tuition fees, living costs and an uninterrupted full salary. This means that many of the nurses are not keen to pay for their own degree because of reasons such as, family commitments and bank loan commitments. Having said that, there are several nurses who went to do just that, and now they appear to relish the sacrifices they have readily made.

However, these problems may have less to do with the doctors' personality characteristics than their lack of knowledge about nursing responsibilities. The old "doctor-nurse game," first described by Stein in 1967, continues to exist. The term 'doctor-nurse game' refers to the implicit or explicit relationships of power between doctors and nurses, and the social game played by both parties to maintain that balance. Many female participants, despite believing their expertise to be more appropriate in a particular situation, still feel the need to defer to doctors. Some nurses have learned and still choose, consciously or unconsciously, to preserve and protect the doctors' traditionally "superior" professional status, by deferring to them at all times. Nevertheless, male nurses such as *Aziz* have reported that doctors treat them more respectfully and with greater collegiality as compared to experienced described by the female nurses. According to *Aziz*, male nurses do not usually experience communication problems or issues with the doctors or nursing colleagues. He feels that the easy-going attitudes of male nurses may contribute to this. This is relatively different from female nurses, who can be emotional at times. Similar views were shared by other male nurses.

The tolerance demonstrated so far by the nurses, however, seems to suggest the creation of persistent feelings of being a 'victim', as suggested by Pyne (1998, p. 90). Pyne (1998, p. 90) further asserts that whilst nurses are still, far too often, treated in a paternalistic and condescending manner:

*We must surely allow it to stir us into asking ourselves an important and difficult question. Is this situation created entirely by others, or does it result from the fact that we have, as it were, opted into the role of victim and then let others consolidate us in that role?*

In most of the interviews, nurses demonstrated a level of tolerance regarding how they were being treated by the doctors. This reflects the findings Wicks (1998, p. 76) in her book called 'Nurses and doctors at work, rethinking professional boundaries' whereby:

*I was able to conclude that these nurses knew very well about their own oppression. They did, of course, know much more than any sociologist. Oppression was part of their daily experience and, when they did experience it, they recognised it and*

*they did not like it. But they also experienced aspects of the work which gave them real pleasure. This seemed to me to be worth pursuing, for it indicated, once again, that nurses had 'made' and continued to 'make' nursing in ways which gave them the space for satisfaction and pleasure.*

Nonetheless, nurses tend to view themselves as subordinate when they feel uneasy about prevailing discrepancies in power. The status quo ensures that nurses regularly feel helpless. As the thesis progresses, it appears that the associations with subservience and maids generally come from the nurses themselves. Nurses certainly did not feel that they were seen as equals and were keenly aware of their subordinate status in relation to doctors. *Junaidah* questions this persistent view held by the nurses; perhaps nurses still have the assumption that they are the handmaidens of doctors, even if the doctors do not look at it this way. *Junaidah* reiterates, doctors may not be directly responsible, in any way, for this subservient perception.

As this thesis progresses it will become clear that many nurses do struggle against perceptions that the 'doctor-nurse' relationship is positive and has improved in recent years. This perception contributes to the widespread lack of self-esteem among nurses that is noted by many authors (e.g. Rosenstein 2002). Nevertheless several nurses feel that being compliant and submissive may no longer be acceptable in today's case; however, such an approach remains evident in practice. In Brunei's context, good conduct means the ability to respect one's superior. Being honest, open, questioning and challenging are not particularly emphasised in workplaces. If something needs to be done, it would have to be carried out in a discreet and implicit manner. Over the last decade there has been a significant move to improve the images and professionalism of nurses that emanated from the Vision 2035 (Brunei Darussalam). This has led to changes in roles and practices for nurses, with increased responsibility and thereby professional accountability. There is substantial literature defining and explaining accountability, but little on nurses' own understanding of this multifaceted concept in practice and the implications of accountability. In a number of studies by Walsh (2000), Watson (1995) and Ferlie et al. (1996), they have highlighted that accountability as a complex

and controversial concept for clinicians working within health care organisations. The studies described the term ‘accountability’ in a variety of approaches, indicating the confusion and paradoxes inherent in the term. With their role expansion the mechanism for professional accountability in practice was considered as an area of confusion for nurses. This perception is reinforced in the interviews, where nurses kept on referring to “having to protect themselves from being blamed”.

What was obvious throughout the interviews was that the majority of the participants referred to doctors as “he or him”. This indicates the gender issue between these two professions; a topic which has been discussed for generations. The medical profession is primarily male dominated, and nursing is essentially female dominated. Carpenter (1993) suggested that gender has been found to be of considerable importance when explaining the position of nurses. It was further argued that it is impossible to obtain an understanding of the doctor- nurse relationship without an awareness of relationships between men and women in society through time (Carpenter, 1993).

## **6.2 THE ROLE OF A DOCTOR**

### **6.2.1 Medical orders**

*Normah* described that verbal medical orders proved to be problematic if they were not then written on the medical notes. When the doctor makes an enquiry the following day and the order (for example blood tests, blood glucose testing) has not be executed, the doctor becomes unhappy. *Normah* verbalised:

*When the doctor gets angry, the juniors just keep quiet whilst some senior nurse would speak out. Sometimes the doctor would involve the ward manager to complain. It is the doctor's fault since they are the one who failed to write the order. There is no black and white evidence. (Normah)*

*Ramli* adds that there is frustration amongst the nurses when the doctor prefers to give a verbal order. An example of this is the prescription of drugs, whereby the patient requests for a painkiller. *Ramli* echoes the view expressed by many of the participants that nurses would prefer the doctors to come to the ward and prescribe accordingly.

Ramli explains:

*Before this, we just give the medication as ordered verbally. Yet there is no black and white, and this is very difficult for the nurses. What if 'things' happen and the patient is allergic to the medicine? This is a form of a bully, you see. They bully us nurses. (Ramli)*

Mariam thinks that the act of following medical orders, and not questioning the orders, usually take place amongst new nurses. In a reassuring tone, *Mariam* was confident that:

*Once these nurses got the experience, only then they will be brave. (Mariam)*

*Ramlah* meanwhile perceived there has been changes, as nurses no longer accept the medical orders per se. She said:

*Now, nurses ask the doctors, why they need to take patient blood. Patient asks, and we have to explain. We have to tell them what we are going to do. (Ramlah)*

*Saloma* echoes the importance of accountability when following the medical order. She suggests that the concept of accountability may not be clearly understood by nurses:

*There are nurses who thought that the doctor has given them an instruction, or an order. And the nurse goes on and carries out the order. Such an act of carrying out the order is the nurse's own responsibility, and not the doctor's. (Saloma)*

*Saloma* further explained that for a nurse who had worked for more than eight years, they usually have a better sense of accountability than the new, less experienced nurses. According to her, experienced nurses tend to learn from their mistakes and from what had happened around them, and thus this pragmatic learning creates a better sense of accountability.

*Samsudin* described his frustration when nurses keep following the medical orders blindly. He said:

*Some doctors keep giving orders, and the nurse just follows the orders and ends up that the nurse got lectured by the other doctors. For example, the nurse makes a patient referral, something that should be done between the doctors, not the nurses. (Samsudin)*

*Samsudin* further notes, with some concern:

*Some nurses simply give common medicine such as Panadol. They said the doctor will sign the medication chart later. If anything goes wrong, say the patient develops an allergic reaction, it is a problem. The blame will go to the nurse, whilst the doctor will not see this as their fault. (Samsudin)*

Samsudin gave an example where the medical doctor had prescribed a drug on a wrong medication chart. As a result, this drug was administered by a nurse. This incident was later recognised by another doctor. The former doctor refused to admit his fault, instead blamed the nurse for giving him the wrong chart; it was a huge relief that the patient turned out to be fine. For Samsudin, the lesson he learnt was not to totally trust a verbal order. He said, nobody will be blamed when nurses administer the medicine, except the nurse themselves. Thus, he strongly believes that nurses should always make an enquiry to confirm a verbal order. Samsudin continues questioning the doctor's knowledge:

*The doctors should know about the medicine they prescribed, right? I remember some doctors prescribe painkiller yet the patient keeps complaining of pain. I wonder if the doctor is up-to-date with their pharmacological knowledge (Samsudin)*

Samsudin argues that the doctor does not always know best. He believes that, similar to the nurses, doctors are 'people too', and therefore they are prone to make errors in their judgments. Hence, nurses must be able to identify and always be 'on alert', when doctors write medical orders. Nash (1995) suggests nurses need to always be vigilant, although nurses are not necessarily to evaluate the doctor's competence or whether he/she is fitted for the job. Nash further suggests that such caution is essential, where doctors may possibly make mistakes when writing prescription.

When talking about the doctor's order, Ramli said:

*The orders can be a lot. Half an hour after their round, there will be more orders. Everything has to be done by the nurses. I feel sorry for the staff nurses. I don't mind helping as much as I can, even if I have to do something I am not supposed to do (Ramli).*

When asked to clarify what he means by that, Ramli explained:

*At the end of the day, it is the nurse's job, our job. I am in the ward and delegated to do the work. If you are given the task to give medication, then you are just going to prepare them regardless of the type of medicine. It can be controlled drugs, IV antibiotics. I have simply been given the task. (Ramli)*

Ramli further listed tasks such as performing Electrocardiography (ECG). He acknowledged that:

*I can do that, although I am not supposed to do it. So far the doctors don't really care who is doing the ECG. If it is not being done properly, they would ask me to do it again. I have learned about doing ECG, but four days is not enough for me. (Ramli)*

Some nurses such as *Ramlah and Normah* nevertheless confess that that they prefer to follow the doctor's order, because they see that as the safest approach. At least, they do not get the blame if things go wrong, they said confidently. These nurses diminish the importance of their actions in the language they use. For example, *Ramlah* speaks of 'but we are just nurses', and *Normah* says, 'Nurses are just to follow orders' as if there have no say. A few of the nurses like *Fauziah* also seemed to downgrade themselves, describing their mindset as follow:

*I cannot make the decision. (Fauziah)*

Whilst nurses like *Aini and Sanisah* saw their involvement during ward round as simply a bystander waiting to be instructed. According to these nurses, when they described that that their responsibility to follow medical orders, what they actually mean is to "merely carrying out tasks". To them, the paternalistic attitudes of the doctors were not an issue at all. The nurses are "used" to the decisions being made by the doctors, without question.

Isabel Robb (1900, p. 250), in the first American book on nursing ethics, wrote:

*Apart from the fact that the nurse may be quite wrong in her opinions, her sole duty is to obey orders, and so long as she does this, she is not to be held responsible for untoward results.*

This 'safest action' of 'to take no action' philosophy is not agreed by the younger nurses who think differently. They oppose blindly following orders because, rather than simply accepting the orders of doctors, one has to be able to distinguish between reasonable and unreasonable orders. They see themselves as professionals with specific ethical responsibilities towards patients; if their perception of these responsibilities



conflicts with the doctor's orders, they feel that they must question or even challenge those orders.

Furthermore, these participants feel that doctors have a limited view of nurses' duties and that they feel that they have the right to speak up if they believe that the order is not clear. Similarly, nurses such as *Junaidah*, who have been studying abroad, tried to change this scenario. For many of these graduates, nurses are viewed as capable, trustworthy and knowledgeable and that nurses are not just there to obey the doctor. *Junaidah* described her experience when studying abroad, where nurses are respected as a member of the health professional team, and that these nurses shared what they think about the patient. According to these graduate nurses, they feel that nurses must begin to take control of nursing. Such determination and courage demands that nurses, amongst others, know what they are about to do. In other words, they must be ready to be challenged if they wish to question the doctor's decision. Aziz, for example, explains how he found the courage to notify the doctors about one prescribed medicine that proved to be failing to make any improvement in a patient's blood pressure reading. Upon noticing this, the nurse had to make several enquiries with various doctors and nurses before he could gain any clarification from the doctor. Eventually the doctor could see his point and ordered a new dosage. This episode illuminates the need for 'sufficient back-up', and further consideration made by the nurse, before questioning any poor or bad practices. Meanwhile, Lachman (2007) suggests that nurses must internalise the willingness to speak out and do what is right in the face of forces that would lead a person to act in some other way. In a Swedish study, Fagerberg (2004) reported nurses' self-esteem to be a crucial aspect in the quality of care they offered. She found that nurses with low self-esteem had difficulty standing up for their patients. Gallagher (2010) put forward the idea that sufficient moral courage would enable nurses to speak up and challenge unacceptable practices. She also recognised that organisations are not always supportive and do not always react appropriately, but rather may act defensively in the face of concerns about standards of care raised

by conscientious practitioners. This could mean that even the most courageous staff may fear to speak up. In this case, it may be possible that a good rapport with the doctor made Aziz feel rather courageous to share his concern. Furthermore, the nurse recognised that, although doctors possess better knowledge about medicine, it does not mean that their judgments are always right.

The Greek philosopher Aristotle (1976 Edition) is known for his notion of means, where one can 'go wrong' regarding courage, either by exercising too much courage or too little courage. He asserts that virtue is linked by two vices, one of excess (recklessness) and one of deficiency (cowardice). With knowledge, for example, several nurses reported that possessing 'sufficient knowledge and competence' appears to be the driving factor for being courageous. For them, the knowledge not only boosts their confidence levels, but also in some way motivates them to be more courageous in practice. Similarly, in a study by Lindh et al. (2009) most of the nurses referred to personal and professional experiences that resembled practical wisdom (Aristotle, 1976 Edition). Banks and Gallagher (2009) suggest that nurses and others who are courageous in their everyday activities require professional wisdom, an intellectual virtue that ensures they demonstrate the right response to the fears they may encounter. A number of nurses such as Aini and *Sanisah* appear to be comfortable with the way nursing is at the moment. Furthermore, they argued that nurses cannot function without orders from the medical doctors. Meanwhile, they accuse doctors of not considering the patient's point of view sufficiently, when they make decisions.

### **6.2.2 Professional judgment**

Different perceptions of the patient and the patient's needs often result in misunderstanding and conflict between nurses and doctors and can become a breeding ground for anger and dissatisfaction. A good example of this is the difference in how nurses and doctors approach and judge patient care. Nurses are cultured to see the

broader health care picture, where they tend to focus on holistic issues and the more human aspects of care.

According to some of the participants, for example, *Junaidah* and *Saloma*, this approach to patient care is opposite to the medical doctors, who have been trained to focus on “the case”; a focus which ensures they often appear to be more concerned with strategies for medical cure or management and less on emotional issues, discharge planning, social and cultural concerns, and helping patients live with their disease and treatment. This statement however is not fully appreciated by the participants. *Ramli*, for example, speculates that this is simply because doctors are not taught adequately about communication skills as part of their general medical education; some may also wish to avoid dealing with intense emotional states in their patients.

One of the many issues that the participant nurses mentioned, when it comes to making judgments on patient care, is regarding the safety of patients. *Kalsom* described an incident where patients were unnecessarily discharged from the ward. She tried to point out to the doctor that patient’s critical levels remains high, and the insulin injection technique was incorrect; the doctor reassured her not to worry since the patient can learn this in the clinic. *Kalsom* described this incident as frightening. She concluded:

*At least I voiced what I thought. (Kalsom)*

Several participants such as *Latifah* emphasised the importance for the nurse to be able to make their own clinical decisions. *Latifah*, who is now working in the clinic, held that procedures such as the frequency in changing wound dressing should be decided by the nurse. She states:

*Nurses can simply do the dressing. It is up to our judgments. If it looks dirty, then simply change it. There is no need to ask for doctor to tell us about the sort of dressing, how frequent to change the dressing or what solution to use to clean the wound. (Latifah)*

For *Latifah*, there are aspects of patient care where nurses can make clinical judgments, and not rely totally on the doctors to make such judgments. *Latifah* further expressed her annoyance by saying that:

*We won't ring the doctor. This thing is something that we can do, rather than asking the doctor. I felt sorry for the patient, having had to eat with the smelly dressing. So we just change it. No need to wait for the doctor (Latifah)*

In another account, *Zaitun* shared a similar account of a situation when a patient asked for medicine from nurses without a prescription. In most cases, nurses prefer not to give medication without any written prescription. Instead they will ring the doctor first. Unfortunately some doctors get irritated when nurses' ask for a simple prescription such as Paracetamol. *Zaitun* explains:

*If anything happens to a patient, doctors would be sceptical and say that we are the one who gave the medicine. This is legal, right? (Zaitun)*

For these cautious nurses, a patient's interest comes first, before the doctor's order. Many of them nevertheless believed that nurses may need to seek help from doctors if a situation involves technical care. In another example, *Latifah* and *Zaitun* shared an incident where a dangerous ward admission occurred. For nurses, doctors do not necessarily understand that some patients may not be safe to be admitted to the general ward, particularly when there is insufficient number of nurses working on that particular shift. As described by several participants such as *Aziz*, *Latifah* and *Zaitun*, having one critically ill patient in the ward can create chaos, given the lack of sufficient nurses around. In some cases, these patients are allocated a "side room", and not near the nurses' station, where nurses can keep an eye on these "less fit" patients. The nurses feel that they do not have much say in the admission of patient into the ward. Some doctors, they suggest, may fail to consider the risk of a lightly monitored "less fit" patient, and possibly expect the nurses to be able to cope. This shows that even allocation of patients creates concern amongst nurses where their safety might be at risk. Both of the participants viewed that there are nurses who demonstrate a passive approach to patients' well-being because, to passive nurses, it is futile to make a 'big fuss' about a medical decision; the easiest and safest response would be to "accept it" by listening to what had been said and move on.

MacKay's (1993) hospital based study, and Williams' (2000) study of primary care, both show that doctors still expect to dominate, seek to dominate, and to a significant degree actually do dominate the workforce hierarchy. At the same time both studies, alongside many other similar investigations, show that dominance is constantly challenged, usually covertly, but often effectively, by nurses who have developed a range of skills and strategies to contain and circumvent medical power. This can be seen here where nurses' may gradually resist medical dominance, where and when appropriate.

### **6.2.3 Teamwork**

Nurses verbalised the importance of teamwork between the nurses and doctors. There are different interpretations of the true meaning of cooperating with doctors. Two fundamental problems for the nurses were that they felt doctors did not value their contribution to the care of patients, and secondly, they feel that doctors do not understand the nurses' roles.

*Fatimah* described the teamwork between the doctor and nurses as progressing, unlike before. She emphasised that:

*We are professionals. They are doctors, and we are nurses! (Fatimah)*

She emphasised that one should not forget that nurses are professionals and therefore expressed the status of such teamwork as "so far so good". Similar to other participants' views, it appears that teamwork can only take place if both sets of professionals see themselves as just that, professionals, and treat each other accordingly.

*Fauziah* described the teamwork in terms of 'correcting' the manner in which doctors make decisions on patients:

*Today we can see that nurses stand up for the patients. We are not defying the doctors, rather we 'correct' them. Some doctors like to coerce matters with patients. They forget that it is the patient's own body. (Fauziah)*

*Mariam* feels that nurses and doctors are working together, and appreciates it when "doctors can understand our roles". However she verbalised her displeasure in dealing

with arrogant medical specialists, who tend to view and treat nurses like “servants”. Her account of good collaboration resonates strongly with accounts from several other nurses in her emphasis on the importance of working with the doctors, and not for the doctors. *Mariani* on the other hand described that there are nurses who are ‘scared’ and ‘anxious’ when they have to deal with medical doctors who are strict and who prove difficult to deal with. She believes that:

*If the doctor is supportive, then they can be fun to work with. (Mariani)*

This ‘fun to work with’ is illustrated in a number of studies such as Rosenstein (2002) and Manojlovich and DeCicco (2007) which advocate that the nurses practice environment and nurse-doctor collaboration were strong predictors of job satisfaction. Meanwhile *Sanisah* commented on the difficulty of raising concerns with doctors:

*Most nurses are afraid to call the doctor when they need to and frequently won't call. Their patients' medical safety is always in jeopardy because of this. (Sanisah)*

When asked, *Sanisah* claimed that such reticent nurses were aware of the potential adverse events that could have occurred from such behaviour. Many feel that they would only call the doctors if a patient's condition starts to deteriorate. Such reluctance in practice may cause the nurses to eventually become desensitised about the patients' situations; the ethical concerns, as Thompson and colleagues argue, are no longer seen as worth addressing (Thompson et al., 2001). Fenner (1980) argued that nurses are often powerless to control nursing practice. She said, if nurses are not given sufficient autonomy of action in the hierarchy of the health care setting, this might have a detrimental effect on the standards of care available to patients. Fenner points out that nurses often find themselves caught in a conflict between two opposing sets of values: the humanist values which may be reflected in their code, and the authoritarian values of the power structure in which they work (Fenner, 1980).

According to some nurses such as *Zaitun*, certain doctors do not recognise the value of nurses' input. They considered doctors to only be concerned with the management

of patients' medical problems, while failing to recognise or take seriously the often-complex care issues that nurses were responsible for. *Mariam* describes a situation where the doctor did not want to cooperate with the nurses, and so failed to let them know that the patient was HIV positive. *Mariam* wonders if the reason for not notifying them was because nurses 'like to tell things', and that 'doctors do not trust the nurses'. She continues:

*Doctors see nurses as gossips. In fact, they are the one who gossip, right? There is an issue of real protocol standard where you have to tell the nurses who are attending the patient for their safety as well. We actually fought for the nurses' right at that time, so thank God we won the case. Nurses need to know regardless how they are, you have to tell them, at certain level, confidentiality is very important, you have to uphold. They only disclose to doctors, but not the nurses because they don't trust the nurses. (Mariam)*

*Mariam* was glad that the patient's diagnosis was eventually disclosed by a doctor who is viewed by many as "respectful toward nurses as human beings". She expressed her relief that the doctor took such an initiative and that "it is very rare to find a doctor like him". *Mariam* speculates that:

*Maybe doctors always look down on nurses, assuming that nurses are gossipers, or maybe not trustworthy, cannot uphold that confidentiality, or because nurses portrayed themselves of not being trustworthy. I don't blame the doctors, seriously, because I have seen nurses who breach confidentiality, and they are my bosses. (Mariam)*

*Mariam's* account on the issue of trust amongst professionals is interesting, because whilst the doctor's act of non-communication was not acceptable, yet they are not to be fully blamed. For *Mariam*, it is perhaps also the nurses' fault for presenting themselves as not trustworthy, particularly the experienced nurses who had breached confidentiality in their practice.

It is difficult not to judge nurses for the lack of trust they receive from doctors. Two incidents experienced by nurse colleagues were shared by the participants to illustrate this point. The first incident was told by *Saadiyah* regarding a nurse's failure to recognise the clinical features of a heart attack. The second incident involved the incorrect assumption that a patient is not to be resuscitated, because the patient is too

old. On both occasions the patients did not survive. The doctors involved did not take further action, except to remind the nurses to stay alert in the future.

The second incident was shared by *Faridah* who suggested that it is perhaps understandable why the nurse did not ring the cardiac arrest team. Not only was the patient old, she was chronically ill. They did not feel that calling the arrest team was necessary. The nurse, however, admits that it is unprofessional to make such an assumption. She believes that a proper and systematic approach has to be in place, so that everyone is aware of the DNR status of patients.

Since these nurses obviously believe that “being heard by doctors” and “treating the nurse with respect” are important aspects of teamwork, the contraindications contained in their accounts may indicate awareness that others do not see this interaction in the same negative light. Saloma, for example, anticipates seeing more teamwork from the nurses, and not the doctor, because “only when the nurses work in a team, will they have more time for patient care”. She points out that nurses must begin to talk and do the work of a nurse, if they wish to be appreciated by both patients and doctors. However Aziz argues that when the nursing workload increases, the nurses find it difficult to find time to communicate with doctors. A heavy workload may reduce the time spent by nurses collaborating and communicating with doctors, therefore affecting both the quality and quantity of nurse-doctor collaboration (Baggs et al., 1999). There also appeared to be a lot of support from the doctors through a number of incidents which the nurses confessed. The doctors were viewed as “more forgiving” and advised the nurses to do more thorough checking on the patients.

### **6.3 SUMMARY**

This section demonstrated the nurses’ attempts to maintain their professional relationship with the doctors, to justify their actions and responses to the ethical concerns that they may have. For most nurses, it is the professionalism amongst the doctors, and the



manner in which the nurses are treated with respect, that provides them with a deep sense of satisfaction. This chapter has also addressed how nurses' understanding of the ethical dimension in their practice was somehow influenced by the relationship with the doctors. In both preceding chapters, the roles and values of the nurses were being challenged. These roles and values are now further tested through an examination of the manner in which nurses situate themselves in the context of patient care, presented in chapter 7.

## **CHAPTER SEVEN**

### **NURSE AND PATIENT**

This chapter explores the relationship between the nurse and the patient in terms of its moral significance. In order to develop this theme, nurses' descriptions of nurse-patient relationships and the implications of these relationships are presented and discussed. In particular I focus on the question of respecting the patient's and family decision in the end-of-life care since this poses one of the most intractable problems for many nurses, and creates considerable ill feeling between the nurses and the patients. I then turn my attention to approaches made by the nurses in addressing patients' needs and interests. I also discuss the involvement of family in shaping decision-making in health care, and how such a process is embraced by the health professionals. The significance of the patient's family's role in patient care will be further examined.

#### **7.1 THE PATIENTS**

The nurse-patient relationship has always been perceived by many as the foundation of nursing practice across all populations and cultures and in all practice settings. It is mainly said to be therapeutic and focuses on the needs of the client. However, in the so called modern world, the relationship has changed tremendously and some nurses may not be ready to be challenged. They prefer the traditional relationship, where patients have to listen to the health professionals, although some patients see themselves as having the right to question and challenge the provision and type of care they are receiving. This can place a burden on the nurse-patient relationship, which may eventually affect the manner in which ethical problems are perceived and responded to.

##### **7.1.1 Good and difficult patients**

Patients are also categorised by the nurses into two types, namely the "good patient" and the "difficult patient".

### 7.1.1.1 Good patient

There are different characteristics of a good patient that the participants have outlined. The two major ones are cooperation and simply “settling down” in the ward; the characteristics which are preferable for most participants. The participants seem to suggest that a good patient is the one who cooperates with the health professionals. *Sanisah* describes:

*In a busy ward, we expect the patients to just comply with the care that we give. It is what is best for them. They need to cooperate with us. (Sanisah)*

This form of cooperation may be similar to the expectation for patients to remain obedient to the nurses. *Normah*, finds that older patients can be relatively stubborn. She stated:

*If the patient says no, you can't actually make them follow to do what you suggest. There are patients who will listen. We also have patients who would only ask help from her family members, and not the nurses. It is a problem if patient refuses to be touched by nurses. (Normah)*

“Settling down” was described in various terms. *Mariani* states:

*I like patients who are just minding themselves by the bedside. They do their own thing. (Mariani)*

Taylor (1979) identified being silent, passive and accepting as the perceived role of a ‘good patient’. Interestingly patients themselves have been sending ‘signals’ to indicate that they are good patients by following what has been instructed to them. This in return will secure ‘good patient’ treatment.

*Saadiah* has a different view:

*I prefer patients who simply don't hassle the nurses. They come and they go. Not creating any problem. These are good patients. (Saadiah)*

According to McDonald et al. (2000) some patients avoided or delayed communicating needs because of not wanting to complain and in an effort to manage their desire to be liked. This professional power over patients is well documented in Parson's (1951, 1975) work on the sick role. In the sick role, a patient is a willing passive recipient

of care provided by a knowledgeable health care provider. The patients freely give up their power to professionals because the latter have specialised knowledge that the patients do not have; professionals willingly accept this power. In comparison with Parson's sick role, Roth's (1972) study of doctor-patient relationships in tuberculosis hospitals found that patients were less likely to remain passive and used negotiation and bargaining to increase their interpersonal power; never, however, to the point of attaining equality.

For *Aziz*, a good patient is someone who is grateful for what was done for them. He explains:

*There are patients who are grateful. Saying thank you to us, for what we did to them. They appreciate us. It's not an easy job, you know. (Aziz)*

In the interviews with older nurses, the participants did not particularly categorise the patient into good or difficult patients, instead they told stories where nurses were to treat patients as they would treat their own family.

#### **7.1.1.2 Difficult patient**

In the present day, the nurses talk about the pressures such as heavy workload, and unappreciative and ungrateful patients who make demands after demands. This has put a lot of strains on the patient-nurse relationship, where the atmosphere has turn into a cold one. Several participants, including Mariani, Kalsom and Saloma articulated having difficulties in dealing with patients who make demands. Mariani, for example, finds that the general public today is "too demanding", and that they are now "too educated" when asking too many questions and making requests to nurses. Khadijah states:

*I have difficult patients who like to question what we nurses do. I know they are educated. They speak fluent English. (Khadijah)*

This creates annoyance for the nurse, which results in nurses labelling the patients and the family as "demanding". "The negative social process of labelling may affect patient

care in the hospital environment and can make staff feel ineffective” (Finlay, 1997, p. 440). The description of the ‘difficult’ label derived from symbolic interactionism is different from earlier research that used patient characteristics, such as medical diagnosis, physical attractiveness, race, gender, and age to define the ‘difficult’ patient. Research shows that nurses who label patients as ‘difficult’ often avoid or distance themselves from these patients (Breeze and Repper, 1998) resulting in less supportive nursing care. This is illustrated in the study, where participants revealed that when a ‘difficult’ patient requests assistance, the nurses will not respond promptly.

Meanwhile it is possibly true that given the wide availability of information nowadays, patients and family members can inform themselves of the patient’s medical situation, although they may not do so accurately. This is why some decide to ask questions of doctors and nurses. This questioning indicates the changing perception of the general public as consumer. There is also growing interest amongst consumers for better provision of health care in general. In the recent years, for example, the emphasis on patient satisfaction has prompted a series of patient surveys and political discussions in Brunei’s annual legislative council meeting. The discussions have focused on public opinion and concern about nurses and nursing in the nation, and suggestions for nurses to take an increased responsibility. However, nurses do not always react positively to being asked about a health matter, because they can sometimes view it as a challenge to their knowledge. In a number of the interviews conducted, patients and relatives who ask questions, or too many questions, were quickly labelled as ‘demanding’ and ‘difficult’. Whilst the number of increasingly demanding and knowledgeable patients and their families is by no means surprising, as acknowledged by the Brunei’s Deputy Minister of Health in 2008, at the same time, the Health Minister reminded nurses on the front line to always strive to do what they can to meet patient needs and demands, hence minimising complaints (The Brunei Times, 2011).

According to some of the nurses, they are just not sure how, or even whether, to give the information to the patient. Thus, some nurses said that they request assistance from colleagues who appear more confident and good at explaining things to do the talking on their behalf. The common excuses given by these nurses would range from “oh, they are asking a lot of questions” to “there are particular family members who are a bit arrogant”. Meanwhile, some nurses suggested that nurses do feel overwhelmed when they find out that patients or the patients’ families are educated and, oddly enough, they identify these educated individuals when: first, they speak fluent English; second, they begin to ask for more information about the patient’s care plan; and third, they ask too many questions. Though the nurses did not admit to feelings of low self-esteem because of their diploma in nursing background, they would implicitly make remarks to demonstrate the comparisons they make when they have to deal with patients or patients’ families who possess a higher educational background than themselves. It is, however, a different case when nurses who have higher qualifications, in particular those who have studied abroad, appear to be able to cope and manage these patients and families without much difficulty. As a result, some nurses try to avoid being in contact with patients and their families, particularly during visiting hours, unless they have to be; for instance when carrying out bedside care.

On the other hand, for some nurses like Aziz and *Junaidah*, it is the manner in which questions are asked, rather than the questions themselves, which can be quite intimidating. The scenario, as described by Aziz, is that “they just want to show off that they know something”. However, *Junaidah* who had experience of studying abroad, and now held a senior position, did not agree. She suggested that in some cases, it is in fact the patients or the patients’ families who feel rather intimidated by the nurses. When a nurse starts to interact with them, these patients and families are not at all as thought of or labelled. In fact, *Junaidah* feels that sometimes it is an image the families need to portray in front of the nurses, as an act of cover-up to ensure they do not feel intimidated by them, and hence it is a way to avoid being seen as weak.

Saadiah also felt sympathetic to the needs of patients and families. She believed that when patients and families appear to be demanding they are, in actual fact, feeling rather anxious, not knowing what to expect. By asking the nurses questions, they would feel at ease that at least 'someone' understood their situation; also asking could be one way to ensure that the nurses who look after the patient know what they are doing.

Nevertheless, to ignore a patient's questions or concerns can have disastrous results, as we shall see from an incident described by Aziz. He shared an account concerning several patients who were due to have blood transfusions that day. There were four nurses working on that particular shift, including one described as rather overconfident. When a blood bag became available on the ward, realising that the other three nurses were busy with other tasks, this nurse decided to perform a blood transfusion on a patient. Unfortunately, somehow the blood types were mixed up. The patient started to ask questions about this, but was reassured by the nurse. Not long after the blood transfusion began, the patient suddenly developed chest pain, had trouble breathing and eventually had to be transferred to intensive care. It was not clear as to what happened to that particular patient, except that since then the nurse has not wished to elaborate further. It is a relief, Aziz says, and that today's practice is far more stringent than before.

Sarimah pointed out similar practice and, in her opinion, lack of explanations could be the reason why some patients do not take their medicine, yet patients are often quickly blamed or labelled as non-compliant instead. The interview with Mariam explained how she would have to caution patients that if they did not take their medicine, they would not be going home and that the doctors would not be too happy with them. When asked to elaborate on her reason for such remarks, she quickly responded that it is something she feels she has to do; otherwise the doctors would not be too pleased knowing that the patient has not taken their medicine. This situation could possibly be the result of failing to see the patient as a human being, as suggested by another nurse.

She feels that nurses must start to treat patients like any other human being, who has good and bad days. Only when we approach patients with respect and communicate in a manner that gains their trust, she said, would patients be able to appreciate nurses and hence accept the suggested treatment and care.

In another context, it seems that patient refusal to go ahead with the care and treatment provided would result in them being labelled as stubborn. When asked to elaborate, Mariam explained that these are the patients, especially older ones, who do not listen and refuse to follow what the nurse has said or suggested, despite efforts to make them understand. Patients who favour assistance from their families, rather than the nurses, would be described thus. In Mariam's opinion, it would make things even more difficult if patients refused to be touched by nurses.

Meanwhile the majority of participants feel that the patient's family behaviour contributes to that patient being labelled as 'difficult'. Rafidah reflects this:

*We had one patient who needed a constant wound dressing change. His daughter is a nurse. As a nurse, she should have known how busy nurses are. At that time, we had at least six admission. We even have to request the Assistant Nurse to help prepare the medicine. Not only that, we have to take care of the doctors. The daughter got angry because we have not change the dressing. (Rafidah)*

This case highlights the competing attributes that are expected in a nurse. Whilst personal attributes of good nursing such as kind, caring, gentle and polite are highly desirable, they are however difficult to achieve on a regular daily basis. Rafidah said that the daughter threatened to make complaint against the nurses despite acknowledging that the nurses are literally busy. Rafidah speculates that:

*The daughter might think that we have ignored the father since she is a nurse. But that is not true. The workload is just unbelievable, and we have to finish all the tasks before the shift ends. Otherwise, we may end up leaving the ward late. (Rafidah)*

Rafidah claims that patients and families often failed to understand a nurse's job. This is illustrated in the following extract:



*When the patient ask for help to clean after bowel open, at times, I can't assist on my own. Cleaning that alone takes about 30 minutes or an hour. I normally ask the patient to bear with me, and to just wait for another nurse to assist. Some patient or their family insist on me doing the change immediately. (Rafidah)*

Maimunah believes that there is a trend where the general public tends to compare the government hospital with a private hospital, or from what they saw in the Intensive Care Unit (ICU) where the ratio is 1 to 1 nurse-patient. She adds:

*In other private hospitals, they see the nurses around, they talk, they comb the patient's hair, they check on the medication. Literally being there for the patient. They focus on the tasks, do the handover in front of them, and listen to them. That's a superb care. But we can't do that here (in government hospital). We cannot be everywhere. We wish we are a super nurse, but we are not. (Maimunah)*

Similar stories were shared by participants who had patients cared for in private hospitals, such as Gleneagles Hospital or Jerudong Park Medical Centre, whereby the hospital fee is fully borne by the Brunei Government. Fatimah, a senior nursing officer, however argued that ideally nursing care should not be any different between government and private hospitals.

Patients are also perceived as “spoiled” when they request assistance from nurses whilst they are relatively independent and mobile. *Normah* illustrated this where patients prefer to use a commode instead of walking to the toilet. In dealing with this, she would remind the patient of the need to be independent; however, if the patient insists, then *Normah* will still help the patient. *Normah* prefers to keep prompting the patient to be independent, whenever it is safe to do that, although the patient may not like it. For *Normah*, this pattern of what she sees as “manipulative” behaviour has to be dealt with in an honest and professional manner.

As a result, *Normah* develop strategies to deal with the ‘difficult patient’. Nurses such as Aini and Rafidah began to demonstrate distancing behaviour, which is evident in the terms they used throughout the interview, such as “We don’t have time for the patient”, “I prefer to be on the nurses station”, and “I don’t want to bother the patient”. Stockwell first discussed the ‘Unpopular Patient’ in 1972. This concept is based upon the premise

that the patient in question departs in some fashion from set norms established by staff of anticipated patient behaviour. Deviation from this set role by patients may result in patient avoidance by nursing staff (Carveth, 1995). Meanwhile Smith's (1992) work *The Emotional Labour of Nursing* offers an account of how some nurses' deal with extreme feelings. Examples included various distancing strategies, such as developing a 'seen it all before' attitude, which made it easier to label patients and their behaviour. Thus, by slotting patients into convenient categories such as 'difficult', 'awkward', 'a pain' or 'a nuisance' and projecting images and assumptions upon them associated with their gender, class and race, they were able to objectify them and their symptoms (Smith, 1992, p. 131).

Meanwhile Khadijah normally advises her staff to avoid answering the questions quickly if the nurses do not have the answer or when they are uncertain about the requests that the patient makes. It is important, Khadijah emphasised, for nurses to not be ashamed of saying "I don't know", instead of giving wrong information to patients or family. The need for nurses to be "knowledgeable" is echoed by *Ramlah*. She states:

*Patients now know things. They ask a lot of things. I mean, Google is just a finger away. Thus, nurses need to be knowledgeable. They need to make sure that what they say to the patient is correct. (Ramlah)*

Junaidah proposed the need for some understanding of the reasons for patients' demands:

*Patients make demands because they are simply being anxious for not knowing or having the appropriate understanding of what's going on with them. Furthermore, if someone is not well, of course they would ask help from nurses. I suppose that's what annoyed the nurses and starts to label the patient (Junaidah).*

Junaidah tried to put herself in the patient's shoes and asked for nurses to appreciate the situation that patients are in. Whilst patient demand is possibly related to rising consumerism, *Junaidah* still believes that it is unfair to label patients as 'difficult' whenever they are perceived as making demands. Gogineni et al. (2015), on the other hand, argues that health professionals must learn to stop blaming patients for being demanding.

### 7.1.2 Patient care

As the participants described the care they give to patients, they began to reflect on themselves as a nurse. The participants offered a number of perceptions of a good nurse. A good nurse is, by definition, someone who is caring towards the patients.

Omar outlines what it takes to be a good nurse:

*A good nurse is someone with a charming personality. It is within the person, where you can't really see it. A good nurse is someone who is a hypocrite. I am an angry person, I easily get irritated, but I have to adjust my emotion when dealing with patients. They are not well. (Omar)*

For Omar, it is essential that nurses must speak to patients in a nice way, and if they failed to do this, patients may file a complaint against them. This reflects the value held by society, where for Bruneians in general, they put a strong emphasis on courtesy and respect, as central to a harmonious community life. Shattell (2002) suggested that patients prefer nurses who are genuine, do not seem to be in a hurry, and are available and willing to talk to them. Some participants, such as Rosnah defend that:

*We wish we can talk to the patients. But in a busy ward, it is almost impossible to have a proper interaction with them. But we will try out best to catch up with them whenever possible. That's how we get to know our patients. (Rosnah)*

Ramlah, on the other hand, finds that some nurses who claim being too busy, so that they do not have time to talk and explain things to patients, is a little exaggerated. She believes that nurses must be able “squeeze in between time and prioritise”. She gives an example when nurses have to collect a sputum sample. Simply giving the sputum bottle to patient, without a clear explanation may result in patient giving saliva sample instead, which may mean that the sample is returned to the ward, and another sample is required. It is about “spending a tiny bit of time” to explain to a patient adequately.

Crotty (1985), Reid (1985) and Hodges et al. (1986) highlight that nurses do not communicate well with patients and approach patients only to deal with administrative or functional activities. Morse (1991), Bergen (1992), Jarman (1995), Hostutler et al. (1999) and Jarrett and Payne (2000) all suggested that this inappropriate communication is because nurses are not aware of the meaning and significance of the nurse - patient

relationship for their patients. This lack of awareness by nurses, results in them making assumptions about what nursing care a patient needs or wants, because they do not ask patients (Bergen, 1992; Booth et al., 1996). This type of communication is not patient-centred and can adversely affect the development of a positive nurse - patient relationship that is essential for the provision of quality patient care. Patient-centred communication is defined by Langewitz et al. (1998, p.230) as:

Communication that invites and encourages the patient to participate and negotiate in decision-making regarding their own care.

A reconceptualisation of the nurse-patient relationship by Hagerty and Patusky (2003), which is consistent to the findings here, suggests that extensive time is not necessary to form a relationship. Samsudin reflects on the time he had with the patients:

When I first start the job, I have time to talk to patients. But now, I am not sure. I mean it is important that we talk. Nurses should just sit down even for a brief moment, ask how they are. Patients will feel better. Today, we see nurses only talk to patient when giving them medicine. (Samsudin)

Samsudin believes that nurses should be kind and patient in delivering care to patients. He sees that the job is a “trust” given by the public, and thus, nurses must not “damage” such trust. The importance of trust and trustworthiness has been frequently emphasised in nursing literature in the context of the interpersonal relationship between nurse and patient (Carr, 2001; Mok and Chiu, 2004; Langley and Kloppe, 2005; Sacks and Nelson, 2007; Berg and Danielson, 2007; Eriksson and Nilsson, 2008).

Meanwhile *Maimunah* described that:

*The challenge that we are facing is the people. People are becoming more intellectual than before. We get to Google everything. We tend to know things. Still, this does not underestimate the importance of our patient needing to be listened to. We do seem to have time to sit down with them. Simply talking to them. (Maimunah)*

Another aspect of caring that participants describe when giving care to patients, is the struggle to maintain the patient's comfort. In an honest tone, Omar admits that:

*I feel disgusted to have to deal with patient faeces. But I have to change my perspective. It is part of the job. (Omar)*

Unlike Omar, several participants described how they have witnessed the suffering of patients, such as when nurses left the patient on a dirty incontinence pad for several hours. Where nurses reluctant to change the patient's diaper, Rafidah offered her view that:

*Some nurses are reluctant to change a patient's pad. If the nurse can pass it to the next shift, the patient will be left soaked throughout the shift. The problem is that, you need two nurses to change the nappies. Therefore if one is busy, the cleaning gets postponed or forgotten. It's like a passing game. (Rafidah)*

Mariam, on the other hand, thinks that there are nurses who do not see the importance of giving basic care to patients. She claims that there are nurses who have the "attitude" of just "getting on with the job" without any need to pay particular attention to a patient's needs. For Mariam, these types of nurses are "not really thinking about putting their heart into the work". She strongly emphasised the need to view the patient as a human being in need, who basically requires attention. She stated:

*These patients are not fussy. If it is me, I can consider myself fussy if I don't get what I want. If you approach them well, you communicate with them very well; they are actually very approachable, regardless of whether they have attitude problems. (Mariam)*

Meanwhile, Rafidah, agreed with the notion that nurses are still working under the doctor's domain. She gives an example:

*Look at the nursing report. It is full with 'cut and paste' writing from the medical notes. Nothing on the patient. There was one shift where a patient complained that he has headache, but it was not written at all in the nursing note. Somehow we dismiss the importance of how patient feels. Nurses are quick to give Panadol. No record of that. (Rafidah)*

In a firm voice, Rafidah questions the writing practice of the nurses when reporting about the patient's progress. She feels that there is a need for nurses to focus on the nursing aspect in the patient care, which is far more important than simply copying reports written by medical doctors.

### 7.1.3 Nurse and status

The image of the nurse, and nursing in general, has been regularly spoken about by the participants. Referring to the social media trend nowadays, Ramli noticed that there has been negative comments made on nurses, and the theme is focused on the absence of caring elements in the nurses themselves. According to Ramli, nurses were labelled as snobbish and rude, which he tries to justify as follows:

*In my opinion, nursing itself is a stressful job. Nurses get tired. Patients and family make a long list of complaints. Sometimes it make us angry. For example, if they ask us, why the hospital TV is not working. They insist that we must make sure that the TV be repaired. (Ramli)*

Samsudin on the other hand, describes the situation differently:

*Some appreciate our job, saying 'thank you'. Whilst others feel that we are paid to do the job. This make some nurses unhappy. We don't mind doing it. I mean when it comes cleaning the patient or feeding the patient, family should be involved because once the patient is discharged, then they are the one who are going to do all that. Instead, we are being labelled as lazy if we asked the family to help. Again, it is going back to the basic attitudes. (Samsudin)*

On the nurse's identity Daud, amongst other participants, feels that nurses are still being seen as domestic helpers. He said:

*Everything we have to do. Cleaning the patients. I mean, the family can do it at home, but once in the hospital, the families automatically don't know how to do it. For me, I will just get them involved. Not only that, nurses are not respected. I mean, hospital is where the nurses work yet it's not respected. People sit on our nurses' station. The visiting hours are not respected. Family and doctors just give orders. (Daud)*

Mariani shared her view on the image of a nurse:

*Cleaning the patient's bowel is something that we used to do, particularly in a medical ward. Some patients see us as "following the doctor's tail". I disagree. I joke with the doctors, but not always. This depends on the doctor's mood and attitude. Oh well, maybe it is true, at times, we become "the tail" for the doctor. (Mariani)*

To improve the nursing image, Mariam did not think that it would be easy to change the negative image, since "attending patient bowel movement" is what the nurses are being paid for. This is what caring means, she said. For her, the job itself may not be appreciated by the general public. Mariam thinks that the perception of the general

public is a difficult thing to change. She however feels that the nurses' negative image has to do with the low payment that nurses receive. Repeated studies of nursing have shown that nursing care of the body is considered dirty and consequently devalued. Socialisation theory, such as Goffman's theory of stigma (1969), is an example. Goffman defined stigma as a visible mark, for example, scars from burns that distinguished a discredited group of people from the general population.

Fatimah and several participants strongly believed that the nurses must remain courteous to the patients; only then will the general public recognise and respect the nurses. Azean, described the "way the nurses' talk to patients" as a way of displaying a caring nurse; caring being what influenced her decision to join nursing. Softly spoken nurses, for example, may be labelled as far more professional and important, than from any other features.

## **7.2 PATIENT INTEREST**

### **7.2.1 Consent**

The majority of the participants, when they recognised the need to tell the truth to patients, they commonly invoked the strong argument that 'it is the patient's body', which is described as the patient's right to know what is going to happen to their body. Emphasis was placed on the patient having to deal with the procedure, whilst ignoring the possible anguish associated with it. It is important to note that patients' rights are not something people consider particularly important in Brunei.

When I researched previous news articles (The Brunei Times, 2008b) I came across a speech made by Brunei's Deputy Minister of Health in 2008 during the launch of the Nursing Symposium at the Suri Seri Begawan Hospital in Kuala Belait. In his remarks, he highlighted that:

*It is the responsibility of nurses to ensure that all patients' rights are respected at all times, and that the patients should have the right to choose their treatment.*



While the statement was highly commendable and rarely mentioned in society, the interpretation of the term ‘patients’ rights’ was seen as rather restricted, if it only means the ‘right to choose treatment’. It was also unclear whether the Deputy Minister was actually referring to such rights under the Tekad Pemedulian Orang Ramai (TPOR) or the Clients’ Charter, which was a courtesy campaign launched in early 1990, in an attempt to recognise the need to provide better public services through transparency and efficiency. I remember having a conversation with an officer with a legal qualification about patients’ rights, in which I asked her about what ‘patients’ rights’ means in the Brunei context. She admitted, in a hesitant manner, that the scope of patients’ rights is elusive and not well addressed; in fact, the only thing she could relate to was human rights.

In the context of health care, consent is approval or agreement sought by the health professional from patients before any treatment or care is provided to them; this care can range from simple procedures to more complex ones. Written consent could be the only category of consent that requires robust information to be given to the patient, and this is made possible only when the patient has received a proper explanation from a doctor.

Rosnah, who has worked as a nurse for more than a decade, told me in great detail about the lack of proper consent that has existed on her ward with regard to ward procedures. One particular procedure Rosnah shared with me is called thoracocentesis, better known as pleural tapping, which is normally performed at the patient’s bedside. It is an invasive procedure to remove fluid or air from the pleural space for diagnostic or therapeutic purposes. A cannula, or hollow needle, is carefully introduced into the thorax, typically after administration of local anaesthesia. She described how the decision was made in rather a hurry:

*The doctor just said, okay, this patient is for pleural tapping of how many litres, and so I want to do a tapping, we need to do a pleural tapping... They take it for granted that, okay, the patient agreed, the family agreed, since everyone agreed, okay I’ll do it today or tomorrow, and carry it forward and do it. (Rosnah)*



Rosnah believes that when a decision is made in a hurry, without giving the patient time to think through it, there is a high chance the consent itself is taken as absolute agreement from the patient, without considering that there are perhaps things that may be taken for granted, such as the need for more information or explanation from the doctors. The concern raised by Rosnah is that the patient's signature should symbolise that the information required by the patient has been given or shared, including the risks involved and what is going to be done to the patient. However, if such a concern were disregarded, she would not be surprised if occasionally there were cases where patients turned up and said, "I did agree to have the procedure, but I had no idea it was going to be like this. If I had known, I would have said no."

Rosnah continued:

*So then you are faced with that thing of, consent should be informed, properly informed in the first place, and yes, the doctor did explain, but the doctor did not explain it properly during the ward round. (Rosnah)*

*Rosnah* also realised that the practice of information sharing, when consent is obtained, needs to change somehow. However, she felt such a change would not take place if only one or two nurses emphasised the need for proper information sharing, whilst the rest remained discreet about the current practice. Furthermore, the absence of any policy drawn up on the issue of consent, and its validity, is making it even more difficult for nurses to insist on, or influence, the doctor's decision.

Faridah shared a story where there was a patient who had a non-threatening ulcer who was told that an operation was the only way forward, whereas some forms of antibiotic therapy may have proved to be more effective and safer than an operation; unfortunately the patient was not told about this at all. The doctor instead used the word 'potong', which literally means to cut off the limbs. She claimed that some doctors seem to overlook that such insensitive remarks may be interpreted in so many different ways, especially with older patients, where potong simply means 'end of life'. Thus, here she felt that nurses sometimes have to correct doctors when they seem to force things on

patients, without taking into account that it is the patient's body at the end of the day. She carefully suggests that playing such a role is not trying to disrespect doctors, rather it is an attempt to help patients to be given other alternatives and opportunities to think about the procedure they are about to undergo. She would also encourage the patient to speak up and let the doctor know what he/she wants. In the end, the doctor took her suggestion into account. In fact, she humorously asked the doctor:

*If it were you, doctor, surely you would not want to be simply potong? (Faridah)*

It is perhaps important to point out that the nurse had been nursing for more than two decades, and her pleasant personality may somehow have influenced the way the doctor responded to her suggestions. Having this rapport with doctors may make it easier for her to make a stand on behalf of her patients. The fact that she reassures the patient to talk and get involved during the discussion tells us that she really wants to keep the patient 'in the loop' as much as possible, without underestimating or denigrating the judgments of the doctors.

Latifah, on the other hand, described the difficulty when explaining about complications or risks from surgical intervention:

*Not 100 per cent shared. It would be difficult if 100%, maybe only 80%. There are certain things we have to hide. For instance, in the operation, we explain, if we do parathyroid, it may hit your nerve around 10%, so it is possible. During the operation, we may also make a mistake where we may hit some nerves, causing facial drop. What happened next was the patient questioned you, why is it after the operation I have facial drop? (Latifah)*

Latifah further explained that, whilst she strongly believes that information is vital for patients who have a right to know the full facts, withholding information might be considered based on two reasons. First, they are only doing their job as a nurse; that is, explaining what the doctor asks them to explain; furthermore the nurse would be blamed for saying such risks to the patient. Second, the risks are uncertain. To tackle this, she now cautiously used the term "sometimes it may happen", even when the doctor declined from mentioning such complications. For the nurse, her truthful

remark is not intended to scare the patient, instead to make the patient aware of such a possibility, particularly when she believed, “we are all human beings”.

Zaitun however, prefers to tell patients that having an operation, for instance, carry some form of risk, and gave the analogy of driving a car. Zaitun claims that driving itself carries the small risk of an accident. However, the participants focus solely on the role of interpreting the doctor’s explanation about the patient’s condition, and appear not to consider the primary role of making sure that patients receive sufficient and understandable information.

Another relevant issue that participants raised is regarding patients’ next of kin. In establishing consent, next of kin proved to be another grey area, as seen by some participants. Whilst consent may be straightforward when it involves parents giving consent on behalf of their children, for Aziz, it remains a vague area when it comes to consent on behalf of a competent adult. In a marital relationship, for instance, he argues that when the wife is the patient, the husband would be expected to consent on behalf of the patient and vice versa. Aziz suggested that if the husband were the patient, then some wives would be reluctant to make the decision to give consent on their behalf, and hence the husband’s family, usually the father, would be called upon to give it.

Aziz recalled the day when a doctor advised a patient with breast cancer to undergo a mastectomy. However, the husband refused and opted for traditional medicine and this decision was respected on the condition that the patient must still receive hospital treatment. When the patient did not appear for hospital treatment, a few phone calls were made, and it was ascertained that the patient wanted to come but the husband would not allow her to. This situation was made more difficult for her because she did not know how to drive. Eventually, after several unsuccessful efforts to convince the patient and her husband, the hospital agreed to respect their decision but to tell the patient that she could come in for treatment at any time. Similar to Aziz’s experience,

a number of participants, such as Rafidah, expressed their confusion on the vague conceptual position of the consent itself, from a legal standpoint, when it comes to a husband and wife situation. Whilst some argue that each individual person is deemed to have a right in granting consent, there are also arguments, given that Brunei is a family oriented society, that consent is a mutual negotiation between the two individuals, and not just one individual's decision.

### **7.2.2 Communicating bad news**

The issue of breaking news, in particular bad news, was first mentioned when I conducted my early interviews. Breaking news normally means revealing to a patient the true nature of their health condition, which is often serious, as in the case of cancer or other terminal illnesses. In this study, participants described how the first discussion in determining the truth disclosure is usually finalised by doctors. In most participants' accounts, when asked about why doctors decide to give truthful information to patients, the general responses they get from doctors is similar to the nurses' own justification, as explained in the previous discussion: 'it is the patient's body'. Again, such justification is understood from the angle of the patient's right to know the truth.

Communicating bad news is one of the challenges that participants described in the interviews. When asked by patients, nurses' easiest option is to ask the doctors the next day, when the patient's family is asked to come along. From the nurses' perspective, breaking such news is the doctor's job; the nurses just "sit and listen" when that occurs. The nurses insist on filling the role of a translator for doctors. Sarimah explains:

*When the doctor wants to tell the patient or the family about the news, I act as a translator, nothing else. I translate whatever doctor is saying. (Sarimah)*

The idea of such a restricted role for nurses is challenged by Samsudin who states:

*I don't think nurses are just being the translator. Giving the news itself is a huge responsibility. We are talking about someone's life. It's not easy. (Samsudin)*

Samsudin emphasised the responsibility that the nurses must be ready to assume, for what they have said to the patient. He believes that:

*Everything that we say or mention to the patient is our own responsibility. We need to be very careful. The patient will digest every single word that we used. (Samsudin)*

This responsibility, according to Mariani, requires nurses to ‘play and twist the words’, in order to ensure the translation itself is appropriate and acceptable. For Saadiah, she sympathised when patients have to wait for a long time before medical colleagues communicate the news. Saadiah explains that she has been trained to break the news, whereby she would give the patients some “hints” first. She can manage this, for example, by having small talks first, and eventually giving her patient the option of whether to go ahead with the treatment or not. When asked about how patients normally respond to being told the truth, participants such as Latifah and Saadiah described that on a number of occasions there was a mixed response from patients. Some would accept it, whilst others would start to wonder why they had such a condition. In most cases, if it involves Muslim patients, a careful explanation by the nurse would emphasise that this is most probably the way that Allah tests individuals and the patients would eventually accept it as qadha (fate).

*Latifah* explains:

*With Muslim patients, they are quite positive with what happened to them. Seeing it from an Islamic perspective helps them to think and act positively. (Latifah)*

In contrast, Latifah described how non-Muslim patients’ acceptance seems to take a while, particularly when the disease is at the final stage, when it is no longer operable or curable. Zaitun continues that the doctors will try to reassure patients, yet be truthful as well. In cases of cancer, for example, the doctors will explain that despite their best efforts, the cancer may return. Similar to Ersoy and Goz (2001) findings, I found that bedside nurses illustrate ethical sensitivity but that their knowledge on ethical decision making models and processes is insufficient and that stop from responding to the ethical concerns that they encounter.

However, Halimah preferred to ask the patient to wait for the doctor to explain to patients for information. Such an approach, she claims, is by far, the safest response. She notes:

*I don't know how to respond to them. I didn't want to upset the patients (Halimah)*

This statement reflects the situation of uncertainty and the tendency of the nurses to pass the responsibility accordingly, because they see that it is the doctor's job to talk about risks. However, it is not always as straightforward as it may seem, as described by Rafidah, who continued her own account about what happened when the procedure went ahead. She said, as a nurse who assisted the procedure, she could not help but ask herself whether the procedure could be stopped when the patient clearly did not want to proceed. After some hesitation, she went to ask the doctor whether more local anaesthetic could be given to the patient or perhaps whether the procedure could be discontinued. Unfortunately, the doctor disagreed with both suggestions, explaining that the procedure must continue because "we are already in the middle of it". Rafidah reflected on how she felt during that time:

*And so you will be like, standing in the middle there, you are not really sure where you are standing, really, because you know it is wrong, in a sense, because if, if you go to the ethics of it, it is consented, but is it a properly informed consent? (Rafidah)*

The above quote illustrates the uncertainties experienced by Rafidah. Central to professional decision-making in healthcare is choosing management strategies in the context of uncertainty. Perhaps the biggest change required of nurses is a social one: nurses need a process of professional socialisation that encourages them to see themselves as active clinical decision-makers. The recognition of the power of clinical decision-making brings with it greater accountability and the need for a visible rationale for one's reasoning. This visibility itself encourages less reliance on unjustified intuition and increases the likelihood of more (appropriate) analytical approaches (Hammond et al., 1987).

### 7.2.3 Role of family

The family role in decision making is recognised in many cultures all over the world. In Asian cultures, the family seems obliged to participate in the medical decision making process, with or without the patient's request or permission (Fan, 1997; Ho, 2006). This current study provides further understanding that even in the cultural context that values the family as a decision-making agent, people have different expectations of family participation in the informed consent process. Similar to the Confucian tradition, in Brunei, the family rather than the individual is considered the centre of all attention, and autonomy becomes collective rather than individualistic. Often, when a patient has a diagnosis of cancer, the first person to be notified is not the patient but the family, particularly the oldest member. This often results in the family making a request for doctors and nurses not to tell the patient. According to participants, such as Saloma, Mariam and Rafidah, this can become a difficult situation particularly when the patient kept on asking for information about their case. Saloma explains:

*When a patient asks, the nurses should try to come up with some explanations and answers. It's difficult, you know. But after working for a few years, we just learn how best to answer those difficult questions. (Saloma)*

The hesitancy to respond to a patient's enquiry is echoed amongst other participants too. A nurse of more than 10 years' experience, Mariam reflected on a dramatic incident where the patient's son was clearly upset that the patient (father) was told about his health condition. Despite the calm attitude demonstrated by the patient, the son was adamant that the doctor had no right to inform his father. Mariam, at that time, tried her best to reassure the son but without much success. When asked about the son's behaviour, the nurse hesitated at first, but went on to speculate that this could be because of the son's lack of medical knowledge. Regardless, as a result, not only did it put strain on the father-son relationship, it also proved to have created more problems when the patient did not turn up for follow-up treatment. This is particularly the case in Brunei, where the elderly usually rely on the children to drive them to hospital. The participants speculate that family members are expected to take on responsibilities,

where children are automatically assume a sense of obligation to care for elderly parents, and make decisions for them.

The majority of participating nurses agree that in Brunei's context, family members tend to decide for the patients, particularly the older patients. The common justification is the anxiety and fear that may be experienced by those patients. Like many other eastern cultures, Brunei is close-knit and family-oriented, and decisions within families are often taken in a collective manner. This is most apparent in cases where elderly parents are unwell, and it is deemed the duty of their children to take care of them. Many generations living together is the extended model norm in Brunei. Several participants described how the typical Bruneian families live together with many generations; elderly women rarely have outside jobs. The men are the breadwinners, while the women take care of the home, children and daily meals. Furthermore, the dominant role of men remains present at individual, family, community and national levels. Decisions such as using contraception, having a child and many others, are still made by the husband rather than the wife.

Wilmot (2003) comments that, on the issue of 'who has a duty of care toward whom within the family' is a matter so lacking in consensus that it is very difficult to suggest any professional role in respect of this matter. Clearly nurses and doctors are both on occasion drawn into exhorting relatives to provide care in order to relieve the pressure on inadequate health or social care resources. This is probably a pragmatic response on, and to suit, many occasions, but that is not to deny that professionals may choose to confront relatives on principle. Dalley (1993) found evidence that some nurses do subscribe to a view that relatives have a duty of care for their elderly and infirm. Whether the promotion of that principle to relatives and patients is a valid professional role is much more doubtful, however. In the absence of a social consensus on this matter, and in the absence of a clear commitment in the code of conduct of the profession, there seems no secure basis for making any firm conclusions.



Some nurses however, expressed disagreement that the family's decision is given more weight than the patient's decision. These nurses consistently felt that patients should be told the truth about their condition. *Junaidah*, for example, disagree when family were told first before the patient. She contends:

*I can understand that Brunei is a family-oriented community. But that does not mean that we forget the patient as our primary concern. I don't think it is right to tell the family first. Why can't we give the decision to the patient first? Let the patient decide whether we can consult the family or not. (Junaidah)*

Junaidah further argued that the manner in which such communication is done, not only appears to undermine the patient as an individual, but also seems to suggest and reinforce the medical professionals' own assumption that 'patients can no longer be trusted to handle and manage themselves'. Latifah puts it in another way, when she spoke about how one of her patients wanted to know their diagnosis, but it was not given because the family had requested that the patient be told nothing. The patient passed away several months later without knowing the true nature of his condition. While Latifah claimed that the practice may have changed in recent years so that patients are approached first, and there is no existing policy or rule of thumb for this, she speculated like other participants that the patient's age appears to be one of the main factors influencing health professionals' decisions. Some of the participants such as *Zaitun* and *Junaidah*, speculated that being old is somehow equated with not being able to understand one's health condition; therefore families' requests to keep the patient in ignorance are often granted by doctors. In a survey by Sullivan et al. (2001) it was suggested that the relationship between age and wanting to be told may be due to the patient's education, rather than to age as such, because age and education were highly related to each other.

Fauziah and Omar capture a common statement among nurses on the importance of maintaining hope for recovery with patients. *Fauziah* explains:

*In Islam, we are obligated to seek treatment when we are ill. But if the family keeps on insisting for us not to tell the patient, it is like we disregard the patient hope. Hope to get better. (Fauziah)*

The act of bypassing patients may be a result of wanting to protect patients from harm or stress, but this may also pose serious implications when the medical staff and/or family underestimate patients' expectations and wishes to participate in the decision-making process regarding their medical situation. This situation is made even worse when such bypasses might actually deprive the patient of hope for their recovery.

On the other hand, participants such as Aziz revealed that in some cases, when patients were competent, their families were not often the first to be informed and consulted in the informed consent process. In Malay culture, families maintain common obligations to share each other's burdens, as well as to protect the common interests of the whole family. The family plays a significant role in healthcare decisions, even if the patient is cognitively capable of acting autonomously (Cong, 2004). In some cases, patients participate in the treatment decision making with their family's agreement.

Meanwhile, the family itself may have their own internal conflicts. Aziz spoke about family conflict and arguments, including power struggles between older and younger siblings about making specific decisions. According to Aziz, when the oldest made decisions, they expected a degree of understanding and deference from their younger siblings. These younger siblings, nonetheless, are said to express resentment about the expectation that the eldest should make all the decisions, particularly when the oldest was not the primary caregiver. Aziz explains:

*The oldest usually discuss with the rest of the family members. Yet they disagree with each other. Today, we talk to the eldest. Tomorrow the younger one will come and speak to us. The next day, it is another younger member. They need to make the decision. (Aziz)*

Most participants like Aziz, however believed that the eldest should have the final say, even if other family members were involved. Prior research has also indicated that relationships may be strained when several siblings attempt to make end-of-life decisions for an ailing elder (Wicher and Meeker, 2012). This study echoes previous findings that contribute to conflict, such as differing care preferences and distrust

between those siblings providing the day-to-day caregiving versus those making medical decisions for the parent.

To some participants such as Sanisah and Omar, there is an over emphasis on the family's autonomy whilst, to them, what is far more important is the family's commitment and determination to help and care for the patient, once the truth is revealed. This disappointment may actually originate from the failure of some families to get involved with the day-to-day care of the patient during hospitalisation. Sanisah further argued that it is essential families learn how to care for the patient, because once the patient is at home, the family members will have to do the caring on their own. Sanisah recalled how she almost got into an argument with a family member who was reluctant to give the patient a nasogastric feed despite being taught several times how to do it. Thus, it is quite logical to see that the issue of family support, in terms of being able to care for patients' needs, such as feeding therapy, would be something that the patient would hope for, no matter how bad or terrible the truth is.

Furthermore, Sanisah believed it is preferable that family members take the initiative to care for patients during hospitalisation for several reasons: they are their parents after all; it is an opportunity for the children to 'pay back' the parents; and the families are the best people in the best position, to look after the basic care of the patients. As Faridah puts it simply:

*Our religion teaches us to love our parents. (Faridah)*

According to Ward-Griffin and McKeever (2000) nurses and the patient's family had 4 interrelated and evolving types of relationships: nurse-helper relationships, where nurses provide and coordinate care, and the family assumes supportive roles; the worker-worker relationship where nurses expect the family members to learn the skills necessary to care for the family member, as illustrated in this study; the nurse as manager/family as worker; and the fourth type of relationship, nurse as nurse/family as patient, was also common. In this type of relationship, family caregivers, who

experienced exhaustion and social isolation as a result of the heavy load of caregiving, became the “patients.”

### **7.3 SUMMARY**

I have described how nurses are faced with the challenge of respecting the patient *per se*. They realised that sometimes they just have to deliberately overlook this value, because of the pressures coming from the doctors and families. This finding further pinpoints the fact that the perception of family participation in the medical decision-making process might be quite individualised. Whilst the majority of the participants preferred that patients be told the truth about their diagnosis, it should be emphasised that none of them preferred that the family be told the truth before the patient. In most cases, the participants verbalised that families had a strong preference for nondisclosure to patients.

## **CHAPTER EIGHT**

### **RESPONDING TO ETHICAL DIMENSIONS**

#### **8.1 INTRODUCTION**

The analysis in the last three chapters, has revealed nurses experience ethical concern in the ward settings, which is generated from the three ethical dimensions in nursing, namely: i) ‘nurse at work’ which illustrates the ethical concerns surrounding the work setting of the nurse; ii) ‘nurse and doctor’ that examines the concern about the role of the doctor in patient care and iii) ‘nurse and patient’ which was generated from the expectation that has arisen from the nurse - patient relationship. In order to reconcile their ethical concerns, one type of responding approaches that nurses engaged in was the attempt to take responsibility to address these concerns. By adopting the following strategies, ‘getting help’ and ‘raising concern’, nurses make attempts to take responsibility to address their concerns.

#### **8.2 TAKING RESPONSIBILITY**

##### **8.2.1 Getting help**

At the outset, getting help usually occurs when they are faced with concerns in the ‘nurse at work’ and ‘nurse and doctor’ domains. This is where the nurses will get help from individuals, such as nursing colleagues; getting help from their colleagues being one of the responses that nurses have adopted whenever they are uncertain about what to do when faced with anything that may affect patient care. For example, in the ‘nurse at work’ section, participants commented on the unclear nursing tasks, which they viewed as conflicts, that they encountered in the ‘doctor and patient’ domain. These conflicts were of primary concern to the safe practice of nurse and patient care itself. According to the participants, once they have experience, they usually chose to focus on the tasks given to them in the nursing work they are engaged in, despite their limitations such as a heavy workload and understaffing. But this is not necessarily the

case for the inexperienced nurses, who expressed of generally trying to get help from the experienced nurses for guidance and advice. These new nurses have to “figure out” which colleagues are prepared to support them in giving them advice. Sarimah explains:

When I first worked in the ward, I only knew a few of them. When I have trouble in making decisions, I have to figure out and be selective in asking for help and guidance. Not everyone is keen to help you, if you know what I mean. (Sarimah)

Many of these new nurses such as Sarimah and *Mariani* believed that experienced nurses are resourceful individuals, but not necessarily accessible or willing to offer assistance if asked. According to these novice nurses, the manner in which experienced nurses assist their colleagues varies, with some negative experiences mentioned by a few. *Normah* shared her story of when she asked for help from senior colleagues during her early career as a nurse:

During my first few months on the job, it was difficult to be able to make decisions on your own. I had few encounters with the doctors and the nurse from other departments. I had to ask for help from the senior nurses. I approached and asked for some advice on what I should be doing. Some are quite happy to help, whilst some would ask me to figure it out for myself. (*Normah*)

This anecdote reflects that nurses rely on their nursing colleagues to support them in practice. The reluctance shown by some experienced nursing team members, who do not seem to support each other in achieving work responsibilities or meeting learning needs, may create conflict amongst their team. However a lack of help from some did not deter these new nurses from approaching other colleagues to seek appropriate support and guidance. According to *Normah*, seeking for a supportive colleague is essential in order to avoid making mistakes:

*At first, I was surprised that some are unwilling to help me. Aren't they supposed to be helping us new nurses, since they have far more working experiences? It doesn't stop me from seeking help from others though. It is very important that I seek help so that I don't make mistakes. (Normah)*

This act of seeking help is reflected in the code of professional conduct (Nursing Board for Brunei, 2010, p. 12) whereby:

Nurses and midwives must possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision. They must acknowledge the limits of their professional competence and only undertake practice and accept responsibilities for those activities in which they are competent.

There are however new nurses who confess to complying with whatever is being suggested by the experienced nurse. Given their wider experience, these 'advisors' are most likely to be treated with absolute trust. *Mariani* states:

I remember one time when I was concerned about one patient's health. I asked the experienced nurse. I simply accepted her instructions with little understanding of what has been said. She is an experienced nurse, so I just assumed that she knows. I mean, it is the right thing to do, right? (Mariani)

The above extract also indicates the assumption and trust held by new nurses that an experienced nurse is viewed as an expert. *Mariani* continued by describing how she ended up being blamed for the decision she made. As a result she felt angry and betrayed, which made her lose confidence in the experienced nurses, which might in turn lead to "trial and error" in her nursing care, with potential negative outcomes for her patients' care. A critical review of the concept of "expertise" in nursing has exposed the myth of universal expertise in nursing arising merely from clinical experience, from being nominated as an expert by peers or from just telling people that one is an expert (Ericsson et al., 2007). In a classic study, Highriter (1969) found no reliable difference between college and hospital trained nurses in their ability to manage patients and

families in acute care. She did, however, comment that this could be due to the fact that nurses work under such time constraints that any difference would be difficult to see.

Junaidah suggests that not all experienced nurses see that “teaching the new nurses” is part of their role. This was reiterated by Fatimah who stated that:

*Learning, for some, should be an individual responsibility that must be taken seriously by the learners themselves, not by the experienced nurses. The nurse must take their own initiative. (Fatimah)*

To Fatimah, doctors are viewed as playing a relatively important role in teaching the nurses, a role which may not necessarily be about technical skills. Fatimah further suggests that, some of these doctors showed the nurses “how to do the nursing job properly”. Whilst Fatimah admit that not everyone likes to be “told” on how to do the nursing job, some nurses such as Saloma see such advice as helpful:

*Sometimes nurses forget and need to be told at times, provided this is done in a professional manner. (Saloma)*

In addressing the ethical concern, participants like Saadiah, Masnah and Junaidah gained help by taking the initiative to learn and improve themselves. Such emphasis can be illustrated when some nurses did take Continuing Nursing Education (CNE) seriously. They strongly believed that CNE is an opportunity for nurses to “increase knowledge” and it is also a nurse’s responsibility to ensure that he or she is updated with the current practice. This responsibility is exemplified when nurses express their willingness to use personal expenses for attending lectures, and spend their own time attending any relevant health-related courses or lectures. According to Mariani:

*It is the nurse’s own responsibility to seek available opportunities whenever possible and we need to do this to improve ourselves. (Mariani)*

There are other participants who suggest that one should not wait to be “told” what to learn; instead, learning needs must be shared with, and identified by, the ward manager. Taking such responsibility is viewed as a form of being professional. This, however



contradicts several nurses who claim that there is no urgency by the authority for nurses to develop professionally on a long-term basis. Aini explains:

*They (the authority) are only interested in sending nurses to pursue degree programmes. What about a continuous and long term professional development of these nurses? Nurses have to engage themselves in developing themselves on a constant basis. (Aini)*

Whilst this is a view only held by a few nurses, the strategy of ‘getting help’ is what the participants perceived to be taking responsibility as a professional.

### **8.2.2 Raising concern**

Secondly, raising concern was another strategy that some nurses adopted in an attempt to reconcile any dissonance in the ‘nurse at work’ and ‘nurse and doctor’ domains. The act of raising concern was illustrated in the previous chapter, where it occurs when nurses insist on ‘following up’, “chasing after the doctor”, or “asking advice from another doctor” when they think that there is something wrong with the medical orders. Aziz illustrates this clearly:

When the doctor writes an order, it is very important that nurses understand what the order is all about. Nurses should not make assumptions. A lot of the time, assumptions can put patients at risk. This results in nurses having to do follow up with the doctors, or even chasing after the doctors. They must raise whatever concern with the doctors or any health professionals when they are in doubt. (Aziz)

When asked if he viewed such an act as becoming the ‘doctor’s handmaiden’, Aziz clarifies:

*I don’t think that is the case. Nurses must remember that the patient is our primary concern. We must not focus on being labelled as such. Our responsibility is the patient and that’s what matters. (Aziz)*

This comment illustrates the emphasis on safeguarding patient safety as the primary nursing focus. Aziz did not dismiss the negative connotation of being labelled as a ‘doctor’s handmaiden’, but rather he wished to focus on the patient’s well-being. For many of the participants, the act of raising concern of any sort requires courage. Nurses

and others who are courageous in their everyday activities require professional wisdom, an intellectual virtue that ensures they demonstrate the right response to the fears they encounter (Banks and Gallagher, 2009). Aristotle (1976) explained two thousand years ago, that courage is developed by habituation. This means that nurses and others become courageous by doing courageous things, by getting into the habit of acting courageously. However, courage is also a reflective activity, requiring self-scrutiny and learning from the feedback and role modelling of others. It is not necessarily the case, however, that a person will be courageous at all times and in all ways. It may be, as Adams (2006) has suggested, that individuals will have ‘modules’ of courage, rather than composite courage. Modules of courage enable a nurse to respond courageously to some, but not all of the situations that encourage fear (Galleghar, 2010).

Sanisah described courage in terms of a nurse’s ability to “speak up”. She reflected upon her experience nursing abroad, where nurses were described as “bold”, and “they say things” and “they compete with each other”. This is very different from the Bruneian nurses, the majority of whom do not possess such characteristics. Fatimah recognised that Bruneian nurses still lack assertiveness:

*Most of them just say ‘yes’ to whatever is being suggested to them. They don’t have the courage to say ‘no’, even if they know they can’t do it, or when they feel they are less competent or when things get too much. They just take it all. At the end of the day, they get too overwhelmed which then result in incidents happening. (Fatimah)*

Nurses such as Faridah, Mariam and Rosnah shared situations where they were asked to do tasks or procedures which they see as beyond what they perceived as the ‘scope’ of their roles. For example, these nurses were being encouraged by doctors to perform medical tasks, such as taking arterial blood gases, as part of the development of nurses’ practice. They reported such act with scepticism, and would raise concern with the doctor that, “I am sorry, but that’s not my job”. Some experienced nurses like Kalsom and Mariam, however, do not mind accepting performing the ‘medical task’. Furthermore, they argue that there were a lot of uncertainties about what can be

termed as nurses' boundaries of work. The study by Davina Allen (1997) illustrated this point further whereby it was shown to be common for experienced nurses to blur occupational boundaries between nurses and doctors.

To some of the participants in this study, for example *Junaidah*, to raise concern was not necessarily about being courageous. Rather it is something that needs to be done for the patient's interest and safety. *Junaidah* presented an interesting issue about the appropriate response, when witnessing poor standards of care by a group of colleagues:

*There was a cardiac event, attended by my staff. The patient unfortunately did not survive. I came to know that these nurses were not fully able to perform basic life support. These nurses just had basic life support training. I am concerned whether they were actually competent. (Junaidah)*

In this case, *Junaidah* felt that she needed to justify whether her concern warrants reporting to her superior. She said that her act was not merely because she is courageous, but she feels that it is just something that needed to be done. *Junaidah* expressed her hesitancy, particularly when these nurses are viewed as "good nurses". It required a long process of deliberation and reflection before making the final decision:

*To report something about your own colleagues' practice is difficult. They are your friend anyway. But at the same time, I have responsibility toward the patients. (Junaidah)*

*Junaidah* eventually raised her concern with the nursing superior. She describes her mixed feelings:

*It needs to be done anyway. I feel okay when I raised the concern, but I still don't feel good about it. (Junaidah)*

The ethical obligation in the Code of Professional Conduct (Nursing Board for Brunei 2010, p. 6) is made clear:

*Nurses and midwives have the duty to inform an appropriate person or authority of any circumstances that may compromise professional standards, or any observation of questionable, unethical or unlawful practice, and intervene to safeguard the client if the concern is unresolved.*

Yet, studies have estimated that only 37% of nurses, who knowingly work with a nurse colleague suspected to be impaired, will report this matter and those nurses

who believed that punitive, as opposed to rehabilitative, consequences would result were even less likely to report their concern (Kunyk and Austin, 2012). Similar experiences were described by several participants, such as Latifah and Zaitun, for example, who shared stories where they reported concerns to the ward manager about their colleagues' poor behaviour whilst preparing medication. Although they admitted their hesitation in reporting, they still went ahead, believing that only the ward manager can intervene and rectify their concerns. They also reported that they needed to know that their ward manager will stand with them and behind them, if they were to address concern about their colleagues. To them, a patient's interest outweighed any fear associated with addressing their concern. Day (2007) suggested that nurses who are morally courageous are able to confidently overcome their personal fears and respond to what a given situation requires, and that they always try to act in the best interests of their patients. Kramer and Schmalenberg (2008, p.69) suggested that:

*Although many nurses are reluctant to complain or make waves, they should remember that they have an obligation to make their expectations known.*

Moral intuition, or moral sense, prompts people to be kind and considerate when encountering another human being in distress (Habermas, 1990). The development of a moral sense or moral identity is embedded in social interaction. Meanwhile moral philosophers and moral psychologists agree that the reason that morals vary is because moral development is entrenched in social relations and cultural norms (Habermas, 1990). Although it is undoubtedly that culture plays no small part in the development of a moral sense, few would disagree that the attitude of respect for persons, regardless how it is culturally manifested, is one of the most universally accepted moral principles that exists.

### **8.3 SHIFTING RESPONSIBILITY TO OTHERS**

This idea represented another type of responding approach that nurses employ to manage ethical concerns in the following dimensions: 'nurse at work', 'nurse and

doctor’ and ‘nurse and patient’. By adopting the following strategies: ‘denying authority’ and ‘keeping quiet’, nurses have engaged in negating any involvement in addressing their concerns.

### **8.3.1 Denying authority**

The strategy of ‘denying authority’ is drawn upon in the ‘nurse at work’, ‘nurse and doctor’ and ‘nurse and patient’ domains. Going back to the reflections made by Latifah and Zaitun, both of them expressed frustration where nothing seems to be done by the ward manager and so adopted the mindset that, “it’s pointless to report”. This frustration then led them to focus on the lack of power to intervene or influence in the ethical concerns raised within their role and relationship as a nurse. According to Latifah:

*It is frustrating when you notice that the ward manager seems not to do anything with your report. It’s pointless. (Latifah)*

When asked if she ever considered approaching the individual nurse, Latifah replied:

*I don’t think that is a wise thing to do, especially if the nurse is someone senior, or an experienced nurse. It is a difficult case. They are your senior, but they have their flaws as well. (Latifah)*

Similar opinions were shared by other participants who disagreed with approaching the individual nurse. Rosnah, for example, described her expectations after sharing concerns with the ward manager:

*She (ward manager) has the power to do something. I expect that the ward manager would do an immediate investigation. She needs to do her own investigations. I don’t think I can say it to her (colleague) face. (Rosnah)*

This point was illustrated in a number of studies such as Penticuff and Walden (2000) whereby nurses often perceive themselves as having little or no power in their institution. They also feel that they know which ethical action to take but are unable to do so, because they do not have the power to change the organisation (Erlen, 2001). In a review of the literature related to nurses’ resistance as an ethical action, the authors established that nurses’ perceptions of their power to resolve ethical problems is

essential to the decision whether to take action, and that empowerment strategies can lead to ethical action (Peter et al., 2004b). In a qualitative study of critical care nurses (Sundin-Huard and Fahy, 1999), it was established that nurses reported that they often felt as if they did not have the autonomy and organisational influence necessary to carry out their professional responsibilities for patients. Meanwhile, cases of nurse managers not listening to, or failing to act on, concerns feature prominently in the literature as a barrier to effective whistle-blowing (Attree, 2007). In management and information studies Keil and Robey (2001) coined the term 'deaf effect' to describe the hesitancy of policymakers and those in authority to hear bad news coming from their colleagues.

Amy Marie Haddad (1993, p.10) questioned the authority that we can assign to nurses in making ethical decisions and wrote that:

*It is clear that support by administration or people in powerful positions is essential for effective ethical decision making. Because we do not make ethical decisions independently or in isolation... Nurses must have confidence that decisions made at the bedside will be supported by nursing administration.*

There are several participants such as Faridah who do not think that being courageous is at all useful, because they feel that courage requires some form of power and authority to go along with it. Faridah offers her opinion:

People talk about being courageous. They speak up against the doctors and the ward manager. Yes, I agree to that. But to do that, one must have some authority I have seen some experienced nurses have such power. Not the new nurses though. (Faridah)

Furthermore, being courageous, *Mariani* argues, brings a lot of negative implications on the nurses such as a strain on their relationships with their co-workers. *Mariani* thinks:

*People don't like to be reported. I have seen cases where nurses who have reported about colleagues unsafe practice. These nurses have had negative reactions when the bad nurse started digging, trying to investigate who made complaints against them. (Mariani)*

This issue of anonymity was mentioned by a number of participants where they strongly feel that ward manager must not breach professional confidence. Anderson (1990) described the hardship on the nurse after exposure of the patient problem as equally worrying, since common retaliations include lack of support, blacklisting and loss of employment. Firtko and Jackson (2005) state that whilst it is not acceptable for nurses, who blow the whistle, to experience the effects as described in the literature, they strongly assert the need for mechanisms in place to ensure that ‘whistle blowing’ does not create undesirable conditions for nurses and other personnel who remain and continue to do good things for the patient.

In the domain of ‘nurse and patient’, the participants did not seem to be particularly concerned when it comes to end-of-life decisions regarding the patient. They expressed slight concern on the basis of the patient’s body, but were far more focused on the actual role of the family in helping with the day-to-day care of patients. Furthermore, for some participants such as Omar and Aini, they believed that shared decisions between the family and the doctors are what is best for the patients. Sanisah explains:

*I may not completely agree with such decisions. Yet family is the one going to look after the patient at home. I guess it is a fair approach. (Sanisah)*

When asked further if she would ever think of challenging such decisions, Sanisah replied:

*I don’t see myself as having the power to intervene or challenge. But, I will try my best to encourage the patient to speak and ask the doctor or the family if they have any questions or concerns. (Sanisah)*

In chapter two, some research-based literature suggested that nurses’ lack of confidence is partly to be blamed on the lack of action or response from the nurses. Lindh et al. (2009), for example, suggested that moral strength involves authority to act in nursing practice. The qualitative study conducted by Lindh and colleagues highlighted that student nurses, despite feeling morally responsible to intervene in care situations where they witnessed healthcare professionals being insensitive towards patients,

often refrained from acting as they deemed they should, simply because of their junior position as nursing students. This reticence was further explained in a study by Ham (2004), where new graduates initially based their actions on individual ethical codes, only to succumb gradually to environmental pressures to conform. In that case, it is not surprising to see some of the nurses were seen to become contributors to ethical problems and violations of patients' rights, rather than enablers in resolving them (Erdil and Korkmaz, 2009). This latter suggestion, however, needs to be interpreted cautiously because it reflects only the observations and perspectives of students, which can be influenced by their personal feelings, perceptions and attitudes towards the health professionals. However, in this current study, it seems that the nurses' relationships and ability to build rapport with the doctors, can be a strong factor in responding to ethical concerns.

### **8.3.2 Keeping quiet**

Another way to shift responsibility to others, was to employ the strategy of "keeping quiet" from saying or doing anything to address the concerns. Some nurses such as Rosnah adopted this approach in an attempt to avoid any confrontation in terms of competing concerns between nursing colleagues, medical doctors and patients. This strategy applies particularly to the two domains of 'nurse at work', and 'nurse and doctor'.

According to Rosnah, there is always an expectation that things are better left unsaid or shared, whereby workplace disagreements need not always be expressed. Rosnah further shares her view:

*In my opinion, there are always disagreements in the workplace. I have my own say, and so does everybody. All of us think differently. But I don't think that we have to say it loud every time there are disagreements. Sometimes being quiet is the best thing. (Rosnah)*



According to Rosnah, the act of keeping silent makes the problem and situation “less tense”. She adds that, keeping quiet is not necessarily a form of weakness, but rather a strength which she describes further:

*Silence is golden. People often forget that. I don't think confronting a colleague is good for long-term relationships. We are not working there for days or weeks, but for years. We must think long term effect. (Rosnah)*

There are also events where nurses are forced to keep silent about their own incompetence. Aziz, for example, recalls a time when he was put as in-charge after only several months of being qualified, where he was asked to give a drug directly into the vein (not via cannula), despite him feeling incompetent. The assistant nurse kept emphasising that “you should know better”. He felt frightened where he had no choice but to make the injection as there were only two of them working during the shift. Aziz describes his feelings:

*I feel like I want to tell the assistant nurse that I have not done the procedure before. But I am scared what she thinks of me then. I am a staff nurse. I should have known better. So I just keep quiet and didn't say anything. (Aziz)*

Aziz reflects on his experiences:

*I felt relieved and lucky I guess. I don't think my technique was correct. But it's done, that's the most important thing. (Aziz)*

Being in such a situation, participants such as *Mariani* expressed concern about the work environment where patient care may be compromised, whilst participants like *Samsudin* and *Omar* reported their lack of concern. Jowett et al. (1991) cautioned that newly qualified nurses may lose their skills as “knowledgeable doers” and “confident analytical thinkers”, as they become socialised into a culture where routine and task based approaches are valued. Several studies such as Mackintosh (2006) and Holland (1999b) recognised the danger of newly qualified nurses becoming desensitised to poor practice habits and even adopting them.

Some participants such as Mariam, Halimah and Ramli put the blame on the ward manager for keeping quiet in addressing conflict between the nurses and doctors. They stated that the ward manager did not normally address the conflict for fear that it will make matters worse. Instead, the nurses themselves are expected to learn to address and solve the conflict accordingly. Mariam, for example, shared her thoughts:

*It is the ward managers who keep quiet when there are conflicts in the ward. They don't seem have the courage to say or do something. I don't understand. Aren't ward manager supposed to be a role model? (Mariam)*

Keeping quiet is also a strategy held by the nurses when it comes to medication errors. This context has been used by a number of participants to illustrate this strategy. According to Faridah, the severity of such errors is judged solely by the nurses. Participants such as Omar feel that if they can still 'manage' the mistakes on their own, they will attempt to do so, without any involvement of others. This will be done by keeping an eye on the patients in case the patient develops any reactions or harm as a result of the nurse's error. Meanwhile Faridah confessed:

*I have made a few medication errors in the past. I only did one incident report. But the rest, I just keep quiet and just monitor the patient's condition. So far, all the patients were okay. (Faridah)*

In responding to mistakes, almost half of the participants in this study, for example, Faridah who assert that mistakes happen for a reason and she embrace such mistakes and try to learn from them. However, responses to such mistakes lies in two major factors: the severity of the mistakes and the consequences if they disclose them by completing an incident report, or by sharing it with anybody else within the ward. To Faridah, being blamed for an error can reinforce feelings of shame and failure and lead to loss of confidence, as well as fear of reprisal (Reeder, 2001). *Ramlah* expressed the importance of keeping the patient's trust. *Ramlah* emphasised this:

*Trust is what matters in health care. Once you breach the trust, then it is a life-time punishment. Your credibility is questioned. People are not necessarily want to know why the mistakes happen in the first place. Mistakes are not well taken by the patients. (Ramlah)*

The arguments for nondisclosure are philosophically based on the principle of beneficence, claiming that some knowledge may harm patients and/or their family and undermine trust in the healthcare being provided (Tuckett, 1998). Furthermore, mistakes are surrounded by a culture of shame and blame, rather than addressing the mistake in healthier ways (Crigger, 2004). Thompson (2001, p. 508) noted that:

*Somewhere in our history of seeking to ensure safe practice and a safe environment, making mistakes became unacceptable, and we introduced blame and punishment. The goal was appropriate, but somehow the outcome is a culture that seeks a person to blame.*

Hence, that could explain why the majority of nurses such as Samsudin and Aziz who admit that they would feel cautious about nurses who have been known to previously make mistakes. They insist that it was not an issue of trust, but somehow they just have to ensure that the nurse does not repeat such mistakes; they do this by double-checking the medication, or reminding the nurse to avoid doing the medicine on their own. Aziz shares his view:

*Once people know that you made mistakes in the past, people will be cautious. It is definitely unpleasant when someone has to keep an extra eye on you. But, I think that's okay. We have to remember that, everyone makes mistakes. We must learn to forgive them, I think! (Aziz)*

But not everyone concur with Aziz's statement. Some nurses such as *Junaidah* feel that the notion of blaming an individual nurse who has made a mistake is still strongly held by many, particularly ward managers. Instead of getting help to manage the mistakes and learn from it, the participants were being "cautioned" by the ward manager and warned that the mistake may possibly be reported in their annual appraisal. Easson-Bruno (2003) strongly suggests that one central strategy to encourage positive teamwork is to avoid the 'blame game', whereby nurses must stop blaming others for problems that exist in nursing. Not only it is counterproductive and unprofessional to blame doctors, administrators, organisations, or other nurses for the unsatisfactory aspects of present-day nursing, but acting like an oppressed group will not encourage others to respect and trust nurses (Roberts, 1999).

Reluctance to disclose relates to the health care provider's attitudes toward herself or himself (Thurman, 2001; Hamm and Kraman, 2001). In this present study, participants expressed fear that disclosing the mistakes they made, may result in negative effects on them as professionals. Professionals who admit to making a mistake risk being viewed negatively by their peers, the administration, and the public (Thurman, 2001). Blaming and concluding poor practice or incompetence stems from health care professionals themselves, while society's pervasive view of health care providers is that they are 'perfect', which Smith and Forster (2000) call one of the 'cherished myths' of our society.

Some participants such as Masnah and Kalsom however expressed the opinion that when a mistake occurs, a fair investigation is a must. At the same time, the individual nurses must also take appropriate measures to protect themselves in the first place from making mistakes. For example, when the doctor's handwriting in a medication chart is illegible, then it is the nurse's responsibility to clarify it with the doctors, instead of taking the risk of guessing what it is.

In the interviews, several participants, for example, Omar saw the mistakes they made as part of "being a human being" and look for the doctor and nursing colleagues for support. Blumenthal (1994) suggested that through humility, we can acknowledge our own limitations. This form of humility or willingness to admit responsibility is embedded when the nurses talk about "being professional". Saadiah suggests that:

*If you are doing something because it is the right thing to do, based on the code of ethics, then that's your back up for whatever action you are taking. Unprofessionalism is when you do things because everybody else is doing it.*  
(Saadiah)

The act of keeping quiet may also stem from the uncertainty that nurses feel when encountering concerns. In Bruneian education in ethics for nurses, critical analytical skill has not been strongly emphasised, and therefore, the nurses may not be sensitive to all the ethical problems occurring in their workplace. In some cases, nurses are

not sure when or if to seek help. Eraut et al. (2004, p. 25) found issues with novice nurses who were “concerned not to look inadequate and to make a good impression as a competent nurse”. These nurses felt that they had to get all tasks done within a given timeframe, with no time for reflection. If nurses are unable to reflect and realise learning opportunities, then this learning goes unnoticed and practice becomes a habit rather than evidence-based (Eraut, 2007). Boud and Hager (2012) suggest nothing affects learning more strongly and unconsciously than the everyday circumstances of work. Rafidah states that, when she is uncertain in what to do, she just proceeded in doing it anyway:

*You just have to be brave enough to do it alone. Being confident. Experienced nurses tend to favour a confident new nurse. For example, in doing IV cannulation. I will make a few attempts first. (Rafidah)*

This feature of confidence is described as essential for many of the participants. The learning environment may have forced the nurses to feel that “getting the skill and experience” was far more important to one’s survival in the ward, even though this may mean that they have to “forget temporarily” their shortcomings. Assumption after assumption was made to justify what they did. In a study by Stacey et al. (2011), the participants acknowledged that the nurses’ values were challenged at times but had chosen not to raise this. In these cases, the nurses accepted they would continue to work within the constraints, despite the personal conflict they were experiencing.

The participants in this study claimed that they would involve colleagues and doctors if they think that the individuals are supportive and non-judgmental about the incident. This is exemplified by some doctors who advise monitoring the patient’s condition when there is medication error. Meanwhile, nurses must be accountable for the quality of care given to patients, and in order to achieve this, it is necessary for them to keep up to date with knowledge and skills, which are continually advancing.

#### **8.4 REASONING FOR THE RESPONSES**

The study has revealed that individual nurses have identified two types of approaches to respond to the ethical dimensions in practice: taking responsibility and shifting responsibility to others. The different approaches that nurses employed have driven the nurses to address and balance the conflict accordingly, and still accomplish harmony at the end of each strategy.

As illustrated in previous analysis in this chapter, the nurses often employed more than one strategy in responding to identified concerns. The nurses responses are being influenced by a good relationship with nurses and doctors; experience of the nurses; internal courage that the nurses possess and the perception of authority. Therefore, for the nurses in this study, their responses to ethical concerns or dimensions in practice were driven by the consideration of the elements of avoiding conflict and maintaining harmony.

#### **8.5 DISCUSSION: ETHICAL DIMENSIONS AND THE RESPONSES**

Findings in chapter five to chapter seven revealed that the ethical concerns that the nurses have encountered in practice, were subjected to three dimensions. These dimensions embedded in 'nurse at work', 'nurse and doctor' and 'nurse and patient'. In the literature review chapter, the responses to ethical concerns varied. The data analysis revealed that nurses often employed more than one strategy in responding to the three concerns in practice, which have been influenced by their experiences, relationships with others and the internal courage that they possess. The consequence of these responding approaches suggests that the response to the ethical concern was driven by the consideration of the two elements, namely avoiding conflict and maintaining harmony. All these concerns illustrate the various conflicts that nurse's encounter in their nursing practice.

What is also common to all of these situations is the fear that may be experienced as the participants considers the cost of the action and the consequences of a particular strategy that they employed. In employing the strategies of 'getting help' and 'raising concern', these are often perceived as the right thing to do as a professional. *Normah* describes this:

*As a professional, there is a duty to do the right thing. This is what professionalism all about. It's all about doing what is right! (Normah)*

At the same time, when the participants act on the above strategy, they have to take into account the consequences of being questioned, and express the willingness to take responsibility for such consequences. Potential consequences however, did not deter the nurses from addressing their concerns in the future. For them, this is part of the nurse's own responsibility for the patient's interest. Amongst the key factors that influence nurses' responses to ethical concerns is the need to protect the patients. Although in the interviews, the nurses may seem to put too much emphasis on completing the tasks, with the ultimate aim to "survive the working shift", there is also a need to protect patients from harm; a need that has been subtly and clearly cited by the nurses. Kelly (2006) reported that a study of intensive care nurses revealed that they tended to use avoidance in order to protect relationships and prevent open arguments.

Meanwhile, in employing the 'denying authority' and 'keeping quiet' strategies, these options are seen as necessary in view of the constraints that they face in the ward, such as the lack of authority, and consequences that they face if they decide to do anything. As discussed earlier, organisational constraints and lack of authority hindered the nurses from addressing their concerns accordingly. This results in them shifting the responsibility to others, such as ward managers, medical doctors and the patient's family. This act of shifting responsibility to others is seen as necessary, since it does not create any further conflicts. Some nurses were said to prefer such 'settling down'.

Faridah offers her view:

*There are nurses who prefer to not have to take things further, if you know what I mean? They rather settle down, not making fuss of what they perceived as wrong. If we can't help to solve the problem, then why do we need to push it? Let someone take the responsibility. (Faridah)*

Dierckx Casterle et al. (2008) conducted a meta-analysis of nurses' responses to ethical dilemmas in their work. They examined nine studies on nurses' ethical reasoning and implementation of their ethical judgment in response to ethical dilemmas in nursing practice. The results showed that nurses tended to reason in a conformist way regarding daily ethical dilemmas, being guided by conventional workplace rules and norms, rather than using creative and critical reflection. The research group also found that nurses have difficulties implementing ethical decisions in more challenging contexts. Furthermore, nurses' conformist patterns of ethical response in daily ethical dilemmas seem to be a universal phenomenon.

In the 'nurse-patient' domain, both nurse and doctor appear to trust the family to make decisions, particularly in an end-of-life situation but, at the same, doctors still play a major role in influencing related decisions. The "patient's body" is often the justification used by some nurses when it comes to information disclosure, whereby there is a need for patients to know what is going on. The participants acknowledged that patients have the right to know, but often the family and doctors trump that right.

Zaitun explains:

*At the end of the day, this is family matter. It involves the family members who would make the decision. There are doctors who would follow the family's decision. There are doctors who would try to influence the decision made by the family. I don't see myself as playing a key role in trying to influence the decision made by them. As much as I think that patient has the right to make decisions, I believe to an extent, the family has such a right. Not much, but at least some rights. (Zaitun)*

The debate surrounding a patient's rights and a family's rights in health care has been addressed previously. Beauchamp and Childress (2001, p.179) for example, suggest that:



*In cases where patients are not capable of autonomous decision-making, the family should be the presumptive authority because of expected identification with the patient's interests and intimate knowledge of his or her wishes.*

According to Seeberg and colleagues (2004), the Western perception of the patient as a rational, self-conscious creature, capable of making his or her own decisions on treatment avenues offered, is insufficient and inappropriate; therefore it must be replaced with a perception of the patient based on 'Eastern' values. An example given is the Confucian philosophy where 'individuals are never recognised as separate entities; they are always regarded as part of a network, each with a specific role in relation to others'. One important implication of the Confucian perception of personhood is that the family, rather than the individual patient, is seen as the primary negotiation partner for the doctor, in the doctor-patient relationship. Tsai (1999, p. 48) explains:

*The doctor should maintain harmonious relationships among families and help to bring agreement out of conflict... in effect seeking to maximise the long term welfare of the patient.*

Seeberg et al. (2004) suggest that there is a possibility that doctors tend not to burden the patient with poor prognosis, and instead, they argue that it is far more sensible to involve the family in such a sensitive situation. The participants also described the pressure that family put on medical doctors. Sarimah describes:

*The family somehow influences the decision on patient care, particularly end of life decisions. What I see in practice is that, the family normally request that we don't tell the patient about the diagnosis and all that. (Sarimah)*

Another factor that influence nurses' responses to ethical concerns is the need to maintain good relationships with workplace colleagues, which many viewed as leading to group harmony. According to participants, the nature of nursing work requires them to work together on a regular basis, and therefore having a good relationship with colleagues is essential. Therefore, some described the need to "fit in", driven by the view that "we cannot be too different from the rest of them", "you want to be accepted" and "I go with the flow". All this data indicates the need for a sense of belonging in order to promote harmony in the workplace. With this belongingness, the individual

will feel acknowledged and connected with a group or team, and which will eventually facilitate group cohesion (Levett-Jones and Lathlean, 2008).

This act of shifting responsibility to others is viewed as something over which they have no control due to a lack of authority, and at times, the person is often seen, or sees themselves, as not ready to take responsibility for the consequences of their proactive actions. Sekerka and Bagozzi (2007, p. 132) have asked:

*What induces people to act in morally courageous ways as they face an ethical challenge in the workplace?*

They noted that nurses practice with moral courage when they confront situations that pose a direct threat to care, which may endanger the patient's safety and wellbeing; therefore the nursing response was argued to be based upon a commitment to serve and advocate for patients and the profession. This however is slightly at variance with this study. The participants respond to the concerns that they have, not because they believe they have a commitment to advocate for patients and the profession but, it was argued, because it was simply the right thing to do. However, this is not necessarily the case when the concerns have to do with information disclosure, whereby the end-of-life issue is not rigidly argued from the context of a human rights concept.

In the employment of these strategies, the nurses are attempting to balance and avoid the conflict in order to achieve the harmony as described previously. Kalsom offers her view on the maintenance of harmony in the ward:

*There is a need to maintain the ward to be as peaceful as possible so that everyone can work accordingly. It is no fun when we work in a harsh environment. It makes the work much more stressful. (Kalsom)*

Whilst such harmony is appreciated, a number of participants feel that the responsibility as a nurse to do good towards patients should not be underestimated. Samsudin says:

*The ward is already a stressful place to work with. But we must always think of the patient's good. That should be our ultimate aim. (Samsudin)*

Whilst a clear division between hierarchies of nurses was apparent, in how nursing team communication was delivered and managed, the hierarchies with the doctors are complex. The challenges of intra-professional relationships are not unique to nursing. Fieldwork studies on peer relationships in, for example, medicine (Bosk 1979; Cassell 1991; Friedson 1975) have generally found a reluctance on the part of professionals to confront, challenge, or discipline each other. In DeMarco's (1998) review of some studies on "constructive confrontation" among nurses, she reported that nurses perceived an ethical dilemma in these situations, in which commitments to maintaining relationships conflicted with commitments to truth-telling.

Nurses were often reluctant to confront colleagues, and tended to shift responsibility for this to managerial personnel. Nursing administrators, meanwhile, were conflicted. As professional leaders, they perceived an obligation to uphold and enforce professional standards, while as mid-level managers they felt an obligation to protect the interests of the organisation (Supples, 1993). In the meantime, some ward traditions and nurses' roles are accepted as what they are, albeit they may appear unreasonable, without any arguments. Previous research reports have suggested that staff nurses tend to avoid conflict with peers, however, and particularly to avoid discussions of errors and problems (Mahon and Nicotera, 2011; Roberts et al., 2009; Siu et al., 2008). Explanations for this avoidance have tended to concentrate on psychological and cultural reasons (Brinkert, 2010; Mahon and Nicotera, 2011; Valentine, 2001).

Meanwhile, the term 'doctor-nurse game' as described in chapter six remains visible, particularly when some of the interaction between doctors and nurses was carefully managed so as not to disturb this hierarchy. The nurses appear as if having had to act within the hierarchy, and subsequently seemed passive. Such passivity however is gradually changing as seen in cases where nurses stood up to doctors, offered advice, and were regarded with much more respect than they previously had been. Therefore, when Stein et al. (1990) made a revisit to the doctor-nurse game, and found that the

nurses were not playing that game anymore, that conclusion can partially be applied in Brunei. The nurses reported they are tired of the 'doctor's handmaiden' image, but they do not, as yet, appear ready to be independent in terms of their duties, skills, and responsibilities.

The responses from the nurses about such ethical concerns had more or less summarised the generic viewpoint on the issue; in the mainstream nurses' minds, nurses had been very caring and professional with the doctors and patients. The nurses' argument had always been that the strong hierarchy of nursing is something which they had no control over. Whilst the nurses attempt to negotiate ethical responsibility, they also believed that the lack of assertiveness and contribution from the ward manager may lead to a huge discrepancy in the image and status of nurses in general. Follett (1977) was one of the first to study organisation-based conflict, suggesting that conflict be viewed as differences of opinions and differences of interest. Follett noted that conflict is neither "good" nor "bad," and that it should be used to identify the sources of differences. Greenfield (1999) noted that nursing leaders (managers) may not be receptive to establishing collaborative relationships with doctors, because this may be seen as reinforcing the subservient role. He recommended that nurses and doctors receive training that recognises the unique contributions of each, in providing quality patient care. Leadership support and education are key elements to improving relationships between individuals with different worldviews (Follett, 1977).

All these strategies lead to the attempt to negotiate ethical responsibility in facing the concerns that the nurses encounter. This act of negotiation will be further discussed in the next chapter.

## **8.6 SUMMARY**

Analysis of the data in this chapter described how nurses addressed ethical concerns resulting from the competing concerns in the 'nurse at work', 'nurse and doctor'

and 'nurse and patient' dimensions. The responding approaches and strategies were employed and discussed. Although it was portrayed in chapters five to seven that all nurses broadly claimed that the responses were rather inadequate, the different responses in practice serve as a reminder that each individual nurse has responded differently to his or her concerns. The nurses were found to be considering the approach that necessitated consideration along with the elements of avoiding conflict and maintaining harmony. In the following chapter, the categories discussed in the six findings chapters are integrated to present and discuss the developed core category from this thesis.

## **CHAPTER NINE**

### **CORE CATEGORY:**

### **‘NEGOTIATING ETHICAL RESPONSIBILITY’**

#### **9.1 INTRODUCTION**

The study has explored how nurses in Brunei describe the ethical dimension in their practice and their responses to that dimension. According to the study’s aim, three research questions were specified. Along with drawing on relevant data to address the research questions, the analysis of the gathered data enabled the development of a core category for this study. The six refined categories analysed in the preceding finding chapters (i.e. chapters five to eight) have presented the ethical concerns experienced by nurses in the ‘nurse at work’, ‘nurse and doctor’ and ‘nurse and patient’ dimensions. Also presented were approaches and strategies that nurses employed to reconcile their concerns, together with the consideration of the elements of avoiding conflict and maintaining harmony which resulted from these response strategies. I have referred to relevant literature to discuss the categories in each chapter. In this section, I integrate the six refined categories analysed in the prior four chapters findings in order to present the core category developed from the data and to indicate how the developed core category can answer the research questions. The core category is diagrammatically presented and illustrated in section 9.2. Section 9.3 indicates how the research questions guiding the study are addressed by linking to the relevant elements of the core category.

#### **9.2 CORE CATEGORY: ‘NEGOTIATING ETHICAL RESPONSIBILITY’**

A core category was developed through the integration of six refined categories and the constituent subcategories discussed in the previous findings chapters. A core category ‘negotiating ethical responsibility’ was identified to explain how nurses described the ethical dimension in their practice, in order to understand ethical concerns that

they encounter in the medical surgical ward setting. The core category, six refined categories and eight conceptual categories were constructed and interrelated and therefore presented in Figure 1.

The core category (see Figure 2) illustrates that the ethical dimension in the nurses practice was presented in three dimensions namely: i) 'nurse at work' dimension through 'nursing work' and 'ward environment'; ii) 'nurse and doctor' dimension via the 'relationship' and 'role of doctor' and iii) 'nurse and patient' dimension through 'the patient' and 'patient interest'.

The 'nurse at work' dimension demonstrates the ethical concerns embedded in the nursing work itself and the ward environment. The 'nurse and doctor' dimension illustrates the ethical concern whereby the relationship and role of the doctor presents a tension between these two groups of health professionals. Meanwhile, the 'nurse and patient' dimension demonstrates the ethical concern that was embedded in the relationship and interest of patient and family. In response to these concerns, nurses have employed two types of response approaches: 'taking responsibility' and 'shifting responsibility to others'. In each approach, four strategies of 'getting help', 'raising concern', 'denying authority' and 'keeping quiet' were employed. In adopting these strategies, the nurses are trying to negotiate the responsibility which may suggest that nurses may only able to take some responsibility for their actions and the outcomes of those actions, depending on the level of experience and the relationship that they have with others.

### **9.3 ANSWERING THE RESEARCH QUESTIONS**

#### **9.3.1 The ethical dimension in nursing practice**

The nurses I interviewed described three ethical dimensions in their practice. The two dimensions, 'nurse at work' and 'nurse and doctor' tends to overlap where they describe their work in some detail. Perhaps the most common feature of the nurses'

accounts of their job was their description of the workload that they have to face. This chapter is concerned with the nurses' description of how they function on the wards and manage the workload. The dimension serves to explain the data related to the nurses' understanding of the ethical dimension of their practice. A number of previous studies of nurses have been carried out which looked into the nature of the nurses' roles, as previously cited in chapter three. The nurses recognised doctors' orders as the key factor informing their role. Most of the nurses suggested that such orders became their main agenda and somehow shaped their approach to patient care. To some, providing that the medical orders were completed, the nurses would admit to feeling competent and possibly, be seen as a professional nurse.

The nurses also described how they managed or coped with such work pressures. The idea of a professional nurse was popular with the nurse respondents. They said that the doctors are only interested to know that their orders were followed and completed, the sooner the better. In describing their workloads on the wards, the nurses I interviewed revealed themselves to be so preoccupied with the workload, that they admitted that this had negatively impacted on the interaction they have with their patients.

The ward environment does not seem to be particularly helpful and supportive for ethical nursing practice, a practice which provides the highest quality ethical care. The stress and tension nurses often feel result in a lack of confidence and ability to address their 'ethical' concerns appropriately. Aiken and colleagues (2008) described the negative impact of the clinical practice environment on a nurse's job satisfaction. They concur that the quality of the practice environment is an ethical issue, because of its important effect on the quality of patient care. Furthermore, Peter and colleagues (2004b) suggest that their practice environment may affect the nurses' sense of health and well-being in the workplace. In a study by Rodney et al. (2006), nurses express frustration and ethical distress when staff and other resources are scarce, and this deficit has interfered with their ability to provide safe and ethical nursing care.



Meanwhile, it seems that too much focus was placed on the importance of teamwork between nurses and doctors. There was, however, a lot of frustration in the manner of how nurses and nursing worked, or did not work, as a team. Many feel that nurses only work with each other, and support each other, if they have ‘clicked’; meaning that they are on good personal terms and are good friends. Those who have some personality clash, or are not on good terms, are expected to manage their differences. As a result, such nurses often end up working on their own. This is in contrast with the point made in the Code of Ethics by the Nursing Board of Brunei Darussalam (2010, p. 10), which suggests that:

*Nurses and midwives must work cooperatively within teams and respect the skills, expertise and contributions of the health care team. They must treat others in the team fairly and without any discrimination.*

On the ‘nurse and doctor’ dimension, the participants repeatedly believe that doctors do not display much respect to them, which subsequently makes them feel isolated and marginalised from other health care professionals. As a result, the nurses look and are nervous when questioned and challenged in their working environment. In some aspects, the feeling of inferiority experienced by these nurses has made them unaware of the ethical dimension of a situation. To some, this has created a vague idea of what may be termed as ethical problems.

The nurses also find it difficult to balance compassion and duties; some would attempt to make recommendations to the doctors, in order to promote and optimise the patient’s well-being and protect their rights, but it is done with caution. The majority of the participants also commented on the conflict they experienced with the doctor pertaining to the role of the doctor in patient care, and the influences that the doctor has on a nurse’s decision. This is not a surprise, because such conflict was illustrated in previous literature. Perhaps one reason that nurse-doctor collaboration is not widespread is that nurses and doctors have not been socialised to collaborate with each other and therefore do not believe they are expected to do so (Keenan et al., 1998).

Sheard (1980) believes that the occupations clash because nurses and doctors structure work in radically different ways and, though they work side by side, they tend to misunderstand the methods and inner logic of one another's work. For example, nurses work on a strictly scheduled hourly basis, sense that a scarcity of resources exists, and are assigned work by room or bed. In contrast, doctors work on a course of illness or case basis and sense an abundance of resources.

Furthermore, several authors report studies that help to understand doctor-nurse conflict and its resolution. May (1995) states that nurse and doctor education is different and that conflict does not reflect the amount or quality of nursing knowledge. The doctor is trained to make decisions concerning what treatment is best and the nurse is not. The difference in knowledge base can be the principal reason for conflict. In clinical practice, however, as well as in the literature, there is a growing concern about implementing ethical nursing practice. Ethical practice seems most problematic in daily ethical dilemmas, arising from situations that involve conflicting values or beliefs about what is the right or best course of action (Ham, 2004). Only some of the participants were ready or able to confront and challenge the doctor's decision, and such confrontation has to take place in a subtle manner. This was illustrated in Rushing's (1965) interview study which suggests a more subtle process, by which psychiatric nurses attempted to gain influence within an overall framework of admiration behaviour. Where nurses felt that doctors' instructions were not in the best interests of patients, they attempted to exert influence through the use of 'power strategies'. This strategy allowed the nurses to demonstrate an expression of unease, but was a method which avoided any open disagreement with the doctor. Therefore, as an alternative approach, nurses might gently mention the matter to ward chiefs and let them take it up with the doctor involved.

In the third dimension, 'nurse and patient', the participants categorised the patients into 'good' or 'difficult'. There was concern expressed by nurses when patients are trying

to get involved, although this may not necessarily be the case in the end-of-life issues involving elderly patients. Patients and families are seen to be far more informed nowadays where they begin to ask for more information; and somehow the nurses feel challenged. This is very different from before, where patients were seen as passive individuals, accepting whatever was being offered to them without questions. Of course there are some patients who are still passive patients, but it seems that they are now wishing to be kept in the loop. When a patient seeks health-related information from the internet and asks confirmation from the health professionals, these patients are no longer seen as passive patients. McMullan (2006) explains that there has been a shift in the role of the patient, from passive recipient to active consumer of health information. McMullan describes that the health professional can respond to the increasing use of the internet by health consumer in ways such becoming defensive, and asserting their expert opinion as a result of feeling threatened. Another choice would be for both patient and health professional to collaborate in analysing the internet information. In a study by Barnoy and colleagues (2009) on the nurses' attitudes towards the informed patient, most nurses held positive attitudes towards patients with internet information; in particular, nurses with prior experience had more positive attitudes towards informed patients than nurses with no such experience. It was suggested that there is a need to prepare nurses to be ready for encounters with such patients.

In examining patient care, the participants began to reflect on the qualities or character of a good nurse. Similar to the findings in the study by Smith and Godfrey (2002), there was a strong relationship between being a good nurse and doing the right thing in patient care. Smith and Godfrey (2002, p. 309) further suggest that:

*Ethical nursing is more than just analytical skill, and perhaps even the addition of intuitive prowess does not capture the whole experience. Rather, ethical nursing is embedded in the wholeness of each person as he or she becomes the good nurse doing the right thing.*

Meanwhile end-of-life decisions were the most common topic raised by participants. Nurses seem to support and agree with the patient's family and the doctor, once a decision is made. This is viewed as the safest approach when it comes to disclosing and sharing 'information' with the patients. The approach is very much framed by the rapport the nurses have with the doctors and the families, which determines the 'next move'. There is evidence that supporting family involvement with the dying person is an important aspect of end-of-life care, for both patient and family (Andershed, 2006). Furthermore, the satisfaction of the patient's family depends on how the family experiences communication and support from the healthcare team (Lowey, 2008). Baggs and Schmitt (2000) concluded in a review of the literature of end-of-life decisions that few studies such as Emmauel (1995) and Asch et al. (1997) have looked at the role of nurses in this process. It is uncertain whether nurses initiate, participate or have any input into such decisions. It has been observed that the distinctions in professional values between nurses and doctors are related to the dying process (Oberle and Hughes, 2001), thus leading to conflict and ambiguity in the clinical setting. There is still uncertainty whether there is consensus between doctors and nurses once the end-of-life decision is made.

Some nurses passively followed whatever the decisions made by the doctors and patients' families. Those nurses also mentioned about the importance of giving some sense of hope to the patients who are seriously ill: hope for recovery, and hope for successful procedures and ultimately, hope that they have done their best for the patients. The nurses did not feel that this was right, particularly when they are forced to pretend not to know anything when asked by a patient about his/her condition or when the patient expresses concern about their condition. However, nurses are denied any authority to disclose case information to the patient, as requested by patient's family. There are many scholars and clinicians who have written on the topics of honesty and the inclusion of patients in making decisions about their care. One of them is Katz (1986) in the seminal work 'The Silent World of Doctor and Patient', whereby Katz

argued that leaving the patient out of the decision making process indicates disrespect to human dignity and autonomy.

The relationship between the patients and nurses is determined by the relationship that the nurses have with the patient's family. Doctors appear to frequently accept the family's wishes to withhold information. This familial preference appears to be unjustifiably influential with doctors, particularly relating to decisions about disclosure to patients of diagnosis and prognosis. In some cases however, the patient requests the family to decide. In this type of situation, the patient will have made clear their earlier wishes to delegate authority to his/her family to make decisions. There were however, no statements made by the nurses on the issue concerning the breach of confidentiality; that is when the family should not have received case-related information in the first place without the patient's permission.

In some cases, however, nurses claim that they will try to talk to the families to tell the patients what they want to know. However this ability to convince the patients' families requires trust between the family and the nurses; if such a climate exists it can be the result of a good relationship and communication between them. Nevertheless the decisions are still belong to the family. Beauchamp and Childress (2001) notes one question rarely raised about familial requests to withhold information is, by what right did the family receive the information in the first place? Perhaps, in Brunei's context, where it is very much family's oriented, it seems that the family provides important care and support for the patients. Hence, their involvement from the outset is seen as invaluable.

On the other, in approaching the subject of end-of-life, nurses illustrate to have a fundamental understanding of the Muslim belief where Muslims are expected to treat illness and death with patience and prayers. Muslims' beliefs about death and afterlife influence their attitudes towards end-of-life decisions, particularly whether to remove life-support equipment. For Muslims, death is believed to be not only the cessation

of a complex set of natural processes, but also a belief that the spirit remains to live and dying is a route from this world to the resurrection. Thus, the spirit is held to be eternal and does not succumb with death. Therefore, while death itself is startling, but when one begins to realise that everyone is returning to God, the experience of death may become less frightening.

The identification of ethical concerns in nursing practice illustrates the ethical sensitivity or awareness of nurses and the nursing profession. Rest (1986) offered a four-component model of moral development which describes steps in the process of attaining moral and ethical maturity. He suggests that one's development of ethical skill begins with an awareness of the impact of a situation upon others (sensitivity). With this awareness, one then decides that there is a need for action and chooses a course of action (judgment). One then makes a commitment, consistent with one's own values and beliefs, to take action (motivation). Finally, one figures out the best course of action for this situation and persists to implement it (action). Without sensitivity to the feelings and reactions of others, ethical actions do not develop. Healthcare professionals often find it challenging to maintain this sensitivity amongst other demands and because of the discomfort that comes with it.

### **9.3.2 Responses to ethical dimensions: 'taking responsibility' and 'shifting responsibility to others'**

In the approach of 'taking responsibility', the participants described two strategies: 'getting help' and 'raising concern'. To intervene responsibly by asking thoughtful and substantive ethical questions about the care, requires significant effort and consideration. Some nurses did initiate discussions with their nursing colleagues, doctors, and at times, the families, about the best interests of the patient. The nurses also expressed their concerns when they fail to do the right thing in situations that could potentially result in harm to the patient. There is an opportunity to use the nurse's voice for the beneficent care of patients, but such a voice has to be subtle, in the manner of a minority voice. In the areas of professional uncertainty, the participants

demonstrated some fear of revealing their own lack of knowledge in front of their medical colleagues. This concern was demonstrated in a study in the operating theatre. Using Goffman's (1969) theatrical metaphors, Riley and Manias (2005) explain a phenomenon of shifts between 'front' and 'back stage' behaviour. They describe the back stage is a physical space where one can be more relaxed and front stage is a space of managed public performance. They further suggested that the effort nurses will often put into maintaining an outward appearance of competence in the operating room as 'front stage' behaviour for a surgeon audience. Meanwhile, nurses may engage in 'back stage' behaviour, such as liaising quietly with each other about a surgeon's preferences, to avoid publicly appearing uncertain. This type of behaviour was noted in the previous chapters where nurses' will speak to other nurses in an attempt to address any concern pertaining to the patient's care or a doctor's order. Although this may appear to be a passive act by nurses, for these participants, this is one way for them to take responsibility for patient care. These two 'taking responsibility' strategies are viewed as promoting harmony in the care of the patients. Only when the nurses begin to take responsibility, can patient care be addressed accordingly.

In the second approach, that of 'shifting responsibility to others', the participants explained two strategies: 'denying authority' and 'keeping quiet'. For some participants, denying authority and keeping quiet, are justified behaviours since doing the right thing is not easy for countless reasons, including fearing retaliation, wanting to fit in, and avoiding conflict. The majority of nurses are adamant that they would try to avoid any conflicts with the doctors. At the same time, some problems were subtle and nurses were unable to recognise them. As a result, the problems went unnoticed and inevitably were taken for granted. Raeve (1993, p. 228) argues that:

Clearly it is in nobody's interests for nurses to be raising objections about medical prescriptions simply as a challenge to medical power. This would be obstructive and unprofessional but where nurses have appropriate knowledge and a genuine concern,

they have a moral and professional responsibility to raise the question. This is because nurses are not accountable to doctors except for the carrying out of tasks that they have implicitly or explicitly agreed to do; rather they are accountable to patients, to the public and to their own professional body. A defence of 'doctor's orders' is no defence for a nurse in law.

Raeve (1993, p. 229) further comments:

*It appears inevitable that as nursing education improves, combined perhaps with changes in the social position of women, doctors are going to have to face increasing questioning of their judgment by nurses. Responding by trying to clarify, in general, the domain of legitimate medical authority may not be helpful, for where good collegial relationships already exist between doctors and nurses, such as questioning of doctors by nurses and vice versa will be experienced as helpful mutual scrutiny. Where relationships are strained or people are simply not used to working together in this way, such open questioning will probably be experienced as interfering and unnecessarily aggressive.*

In keeping quiet, the participants expressed their uncertainties how to respond. Despite a high level of sensitivity and a fair amount of knowledge and understanding of ethical concerns, they were uncertain about whose interests should take priority. Some problems were recognised and the nurses responded appropriately with the patient's interest coming first. The conversations with families and patients about goals of care, tended to be shaped by the wishes of the family members. The allowance of family (and patients, at times) to ask about and discuss the patient's illness tends to be a one-off event rather than an on-going event. Furthermore, there is no ethics committee available in this country, which can help the team decipher what is in the best interest of the patient and family.

Nurses' seem to seek the safest approach when it comes to telling and sharing 'information' with the patients. The approach is very much framed by the rapport they have with the doctors and the families. This extent of rapport between these people somehow influences the 'next move' that the nurses take. There are a small number of nurses who seem to passively follow the decisions that have been made by the doctors and patients' families. As a result, nurses often submit to the decisions made by



others, which results in a conformist way of acting and less individually adapted care. Conformist practice, following conventions rather than pursuing good for the patient, constitutes a major barrier for nurses to take appropriate ethical actions, because creativity and critical reflection are absent. There is a pressing need to find ways to promote nurses' ethical development from conventional to post conventional ethical practice. Nevertheless these two approaches to the strategy of 'shifting responsibility to others' have been perceived as essential, although passive; at least, the concern will be dealt with accordingly by others with authority and power.

### **9.3.3 Reasoning for the response: avoiding conflict and maintaining harmony**

The study's findings revealed that the nurses were able to recognise the ethical nature or dimension of their work. The responses via the employment of various strategies are related to a number of factors: first, a good relationship with nurses and doctors; second, the experience of the nurses; third, internal courage that the nurses possess and fourth, the perception of authority.

The first factor is the rapport that nurses have with everyone involved in providing patient care. The nurses recognised the ethical dimension of a situation in practice; it is normally involved in a relationship with others, such as the patient, patient's family, doctors, ward manager and colleagues. The term 'best interest' is commonly surrounding the best interests (interests translated in practice) of everyone else in the ward, and not necessarily solely the patients. For these nurses, when taking into account their own interest or survival, it is their survival that comes first, before everything else. In addressing any ethical problems, they would have drawn upon the consequences of their responses to the situation; the nurses are able to see the potential ethical issues that might arise in health care provision.

The second factor is the experience of the nurse. Kohlberg's theory of moral development (1958) provides a useful framework for understanding how one's personal ability to make moral judgments is influenced over time by personal development, knowledge

acquisition, experience, and the environment (Ketefian and Ormond, 1988; Cohen and Erickson, 2006). Individuals at the highest level of moral development are said to be using their conscience to determine the right course of action by independently examining and delineating moral values and principles rather than by relying on group norms (Ketefian and Ormond, 1988).

The third factor is the internal courage of the nurses. The work-is-work ethos which emphasises duty has been mentioned repeatedly; however, when asked further, they struggle to provide clear explanations. Courage is equivalent to being professionals.

The fourth factor is the perception of authority. In addressing ethical concerns in practice, the participants questioned the issues surrounding authority. Some of the nurses did not feel that they have the authority to question areas that they viewed as organisational constraints, such as understaffing or the decision made by the patient's family. Furthermore, some nurses appeared to be preoccupied with seeking acceptance from the surrounding personnel, so that they may be perceived as acceptable, as a norm, as a whole. This can be illustrated where some nurses in this study preferred to take in the doctor's order. For them, taking such an order is a necessity for the nurses to be able to provide patient care. This is in contrast to a study by Kerzman et al. (2015) where nurses reported positive attitudes toward the expansion of nurses' authority and moderately supportive attitudes for interpretation of diagnostic tests in selected situations. The results demonstrate that the nurses' satisfaction from professional autonomy and work relations were the most influential factors in explaining their attitudes toward the expansion of nurses' authority. In addition, young nurses tended to be more positive regarding changes in nurses' authority. Rowden (1984, p. 219) former director of nursing services at Royal Marsden Hospital, London, wrote:

*The nursing and medical professions are totally interdependent, it is therefore essential that we learn to share major issues, establish dialogue, and learn to accommodate each other maturely.*

These nurses know that there is a right thing to do, but feel that in some circumstances, the system they are in does not allow them to act. It is worth pondering the point that inaction in some areas of practice is seen as both acceptable and appropriate in most cases. This could possibly be a form of moral distress, as theorised by Jameton (1984), whereby nurses who know the right thing to do, but cannot pursue the right course of action because of institutional constraints. This stressor is further evidenced from the interviews, where nurses shared their frustration at not being able to do what they knew was right.

A number of studies such as Konishi and Davis (1999) and Bunch (2002) have been published about nurses' moral problems. What is startling is that most often, nurses do not recognise those moral problems. The failure to do what the nurses think is right, because of institutional constraints, may lead to the experience of disequilibrium and painful feelings, which Jameton (1984) called 'moral distress'. Unlike in some places where moral distress can lead to burnout and compromised integrity, where such affected nurses may possibly leave the profession (Corley 2002); this has not been the case in Brunei. The majority of the nurses are employed by the Brunei government; a position that is not only considered as a privilege, but it also financially secure. This means that despite being in a constrained and at times morally distressing environment, nurses do not have much choice other than to stay in their job and keep working.

All these factors influence the type of response approaches that they adopted in order to deal with their ethical concerns which resulted in the elements of avoiding conflict and maintaining harmony. These elements raises an interesting question about maintaining personal integrity as a professional nurse, where nurses have to contemplate whether to go ahead and conform to what others are saying, or one can continue to proceed on the basis that it is the right thing to do. This situation is in contrast to the socialisation perspective, where nurses usually work in a collective manner, and hence team consensus is seen as central. The 'fitting in' concept can be used to understand this

context, where it does not only apply to new nurses who tend to try to fit into the ward environment and its mores, but it is a dynamic process nurses are employing in order to be accepted. This can be illustrated particularly in the dimensions of 'nurse at work' and 'nurse and doctor'. Regardless of the strategies the nurses employ, those strategies must not upset the harmony within the nurses' roles and relationship, with others. What needs to be noted is the concern raised by Laabs (2011) based on research investigating new graduates' perceptions of moral integrity. Laabs (2011, p. 431) writes:

*Nurses who act contrary to their own values and beliefs to do what another person asks of them without questioning are at risk of becoming morally desensitized to their own conscience. Some nurses actually begin to think they will never be the kind of ideal, moral nurse they aspired to be.*

In the 'nurse at work' and 'nurse and doctor' dimensions, the participants would see the patient as the reason for them to carry on, especially during stressful times. Meanwhile, in 'nurse and patient' dimension, the participants verbalised that whilst the majority strongly believe in respecting patients, they also accept the family involvement in decision making, although the nurses do not necessarily agree with it. For the nurses, the family-oriented system in Brunei is highly influential in determining what is good for their patients.

The participants are not relatively certain about the dimensions of the ethical responsibility placed on them as a professional nurse. Whilst the authority continues to encourage nurses to take greater responsibility in general practice, and to practise good patient care, there is a confused message coming from the authority regarding the need to be a professional nurse who provides ethical patient care. Whilst at the same time, the relevant authority places a stronger emphasis on professional etiquette over professional ethics; for example the importance of good manners that the nurses should display, as well as being courteous and sincere. Whilst a professional manner is highly important, it is not necessarily sufficient to enable nurses to address ethical concerns. The ethical dimension in nursing practice arguably requires nurses to respond beyond the etiquette expectations placed on nurses.

One salient point that emerged from the interviews is on the value of being a responsible individual nurse. With conformity, therein lies the problem of accountability. Despite the nurses beginning to appreciate that nursing practice can no longer be based solely on the methods and techniques of the past, the 'present tolerance' from the relevant authorities in ensuring the standard of practice is maintained accordingly, is seen as a hindrance factor. Such tolerance is illustrated by the absence of legal cases brought against nurses. In a worst case scenario, nurses will only be suspended or have their salary withheld for a certain period. It was also suggested that such incidents are not even made transparent by the Nursing Department or the Board itself.

Both approaches, of 'taking responsibility' and 'shifting responsibility to others', illustrate how nurses try to find their unique balance in addressing the responsibility that they perceive within the ethical concerns that they encounter in practice. Their efforts have resulted in the development of a core category, 'negotiating ethical responsibility' (Figure 2).

#### **9.4 SUMMARY**

In practice, nurses have described three ethical dimensions that they encounter in practice. The core category 'negotiating ethical responsibility' was developed through addressing the research questions for this study in order to provide an understanding of how nurses in Brunei describe their ethical dimension in nursing practice. As a consequence of the negotiation, the elements of avoiding conflict and maintaining harmony may offer some understanding of how the dimension is responded to by the nurses. Nurses have identified some sense of responsibility to address the three dimensions but they negotiate the responsibility, in view of wanting to avoid conflict, and hence maintain harmony at work and with others. Therefore this study has illustrated the significance of enhancing this responsibility, by addressing ethical dimensions encountered in the context of nursing practice in Brunei; in particular nurses' concerns at work, and their professional relationships with doctors and patients.

## **CHAPTER TEN**

### **CONCLUSIONS**

#### **10.1 INTRODUCTION**

This chapter concludes the thesis. It begins with a summary of the study along with my personal reflections on the research process. The implications of the research findings for nursing practice, education and wider policy are considered. Recommendations for future research are offered at the end.

#### **10.2 SUMMARY AND REFLECTIONS ON THE RESEARCH**

At the outset, the interest to conduct the study began in the early years of my ethics teaching to a group of nursing students. I then began to look into the historical state of health care, nursing practice and nursing education in Brunei; in particular how ethics is taught in college where the issue of medical ethics is part of the curriculum. The literature review illustrated various ethical dimensions in nursing practice and that the nurses' responses, as well reasoning, are influenced by a number of factors.

With the aim of examining how nurses in Brunei describe and respond to the ethical dimension of their work, the research questions were then developed:

- (1) What is the most difficult situation you are involved with in the ward setting?
- (2) How do you respond to that situation?
- (3) What are the reasons for your responses?

The research focus was identified as an under-explored area, particularly in the context of Brunei. My purpose of this research was to gain an in-depth understanding of how nurses describe the ethical dimension in their work practice. Therefore grounded theory was chosen to guide this study. I was however uncertain in choosing the different

versions of grounded theory. Upon considering my epistemological and ontological stance, and previous relationship with the potential participants, I chose Charmaz's (2006) constructivist grounded theory to facilitate the study.

My fieldwork was conducted in three hospitals in Brunei, from December 2011 and then from April to August 2012. The recruitment procedure was guided by a combination of purposive sampling and theoretical sampling. Data was collected through interviews with 28 nurses. The process of gaining access to participants and finally setting up the interview schedules proved to be relatively challenging, particularly when the ward manager nominated a list of nurses to attend the briefing. I was requested by the nursing authority to submit name of participants for administrative purposes. The interview process was both rewarding and exhausting. My background, as a former nursing college student and now a nurse lecturer, helped to establish rapport with participants and encourage them to share their perceptions and experiences. I had to constantly challenge my own perceptions on what has been raised by the participants and this was done by writing memos and a research diary. Before the interviews I had made the assumption that nurses' might perceive ethical problems from medical or bioethics perspective and that the nurses are caught in the doctor-nurse game, which may mean that nurses do not make any ethical decision at all.

In data analysis, after the process of transcription and translation, I employed the coding procedures suggested by Charmaz (2006). As a novice grounded theory researcher, the Initial Coding itself has led me to a total of 600 codes. After going through several stages of constant comparison and the classification and categorisation of data codes, the codes were assembled into twenty six abstract concepts (see Appendix F). In the end, eight conceptual categories were co-constructed, and followed by the co-construction of six refined categories were identified from the study: 'nurse at work'; 'nurse and doctor'; 'nurse and patient'; 'taking responsibility'; 'shifting responsibility to others; and 'avoiding conflict and maintaining harmony'. The integration of the

refined categories has developed the core category ‘negotiating ethical responsibility’, which suggests that the ethical dimension in practice is a constant negotiation of responsibility by the nurses, in an effort to avoid conflict, and maintain harmony in practice. The core category indicates that the nurses employed two types of responses in the avoidance of conflict and maintenance of harmony: ‘taking responsibility’ and ‘shifting responsibility to others’. Illustration of the core category and discussion of how the developed category ‘negotiating ethical responsibility’ has answered the research questions were detailed in chapter nine. The implications of the key findings in this research are considered in the following section.

### **10.3 IMPLICATIONS AND RECOMMENDATIONS**

#### **10.3.1 Nursing practice**

Having the support of a strong ward manager enable the nurses to work in a better environment, better staffing ratios, better functioning teams and greater nursing autonomy. Research has also revealed that a positive ethical climate is one in which nurses experience recognition and cooperation, support for nursing values and abilities, and opportunities to act on their beliefs (Peter et.al, 2004a). Therefore the ward managers and the relevant authorities should not quickly dismiss nurses’ ethical concerns; instead they must find ways to address the concerns in a professional manner. Peter and colleagues (2004b) described a positive ethical climate as one where nurses experience recognition and cooperation, whilst at the same time there are opportunities for nurses to act on nursing values and beliefs. Most importantly, such climate also allows nurses to address unsafe, unethical or bad practices or situations that may jeopardise safe, high quality care. However this may compel the ward manager to stand with them and behind them; and that they need to know that their views are indeed, welcomed, valued and respected.



If the Ministry of Health is serious in helping nurses to maintain their caring and professional role, they need to find ways to improve the standard of practice. Examples of how to achieve this goal include regular staff meetings, an ongoing ward teaching policy and learning between professionals, as well as by creating an environment which nurtures a supportive and non-blaming practice. Ward managers may also consider having debriefing sessions for nurses who have been faced with difficult moral issues, whereby individual nurses can reflect on their own practice. This reflection would eventually allow nurses to find that the language of ethics can help them to express their concerns accordingly (Canadian Nurses Association, 2010). This is in line with the recommendation in the Core Competency Standard (Nursing Board for Brunei, 2013, p.10) whereby nurses could:

*Take control of their own learning and development by engaging in an on-going process of reflection and action, as part of lifelong learning.*

Whilst there seems to be a long established interest in encouraging nurses to present themselves as a professional nurse in the aspect of image and being courteous, that alone is not sufficient for nurses to address ethical concerns in practice. Also, if the relevant authority desires Bruneian nurses to uphold and maintain their professionalism, the Ministry of Health must support and encourage this goal through constant emphasis on the current professional structure documents which helps nurses take professional responsibility for their decisions and actions.

There is also a need to question the absolute expectation that nurses can and will cope in any practice environment that they are placed in, particularly when understaffing is viewed as a real concern. The Code of Ethics (Canadian Nurses Association, 2008, p. 9) states that:

*When resources are not available to provide ideal care, nurses collaborate with others to adjust priorities and minimise harm... They inform employers about potential threats to safety.*

The relevant authority cannot merely presume nurses to be able to cope and manage in, and with, poor and unsafe work environments, particularly when nursing care itself involves the humanistic aspects of care. Just because the nurses can and do cope, it does not mean that it should be taken as acceptable and that it is to be borne. For the practicing nurses, they also need to find a balance between being a technical nurse and being a professional caring nurse at the same time. Every nurse needs to challenge this old concept where the nurses are merely following the doctor. To succeed, this challenge requires the relevant department to strengthen the nurses' knowledge and skills. This means that there is a need for equal weight of both being a highly technical nurse, yet at the same time, a caring one too.

Positive learning environments are created through good leadership practices, where staff openly verbalise situations and feel that they can trust each other (Paterson et al., 2010). On the other hand increased collaboration between nurses and doctors, for example, via regular staff meetings, helps move all clinicians away from a hostile 'us versus them' mind-set. Ward managers can encourage collaboration by regularly asking doctors and nurses for feedback on communication problems. Programmes that promote interaction between medical and nursing students help these future professionals to understand each other's roles and responsibilities better. It is not surprising that nurses and doctors still have relationship problems, because these conflicts are rooted in human factors such as personalities, attitudes, feelings, and communication styles. For things to change, nurses have to approach the problem directly and initiate strategies to improve the situation, rather than merely complaining about them. This emphasise constant reflection and awareness of one's own practice and the effect it can have on others, and of the importance of advocating for what is needed to make the moral community strong.

At the same time, a comprehensive understanding of nurses' uncertainty in practice will advance nursing knowledge that can guide both nursing education and

practice. Understanding nurses' uncertainties can also lead to the development and implementation of strategies to support nurses in their clinical decision-making and practice. For example, understanding how nurses experience uncertainty at different stages in the clinical decision-making process could lead to the design of targeted interventions. Therefore, nurses need to be equipped with the skills, tools and confidence to recognise uncertainty; one remedy is to design feedback about decisions into daily work patterns.

In the meantime, nurses must begin to respect themselves first, before seeking respect from others and must begin to take responsibility. The Canadian Nurses Association (2010, p. 12) determines that:

*Development of a positive work environment starts with effective leadership, as it takes a leader to make things happen. Managers are key, but individual staff nurses are also responsible for demonstrating leadership in ethical practice.*

Many previous studies have supported the view that ethics education plays an important role in gaining skills for coping with ethical problems, taking an active part in the decision-making process, and gaining a professional identity (Lewenson et al., 2005; Auvinen et al., 2004; Altun and Ersoy, 2003; Davis et al., 2002; Varcoe et al., 2004; Joudrey and Gough, 1999; Doane et al., 2004). However, the expected positive impact of ethics education may only occur if this knowledge is internalised by members of the profession and integrated with their experiences. Doane and colleagues (2004) suggested that nurses who received such education during training, and had long experience gained from working in healthcare contexts, were observed to have better ethical decision-making skills.

Meanwhile, there is a need for both professions to examine their determination to develop on an interprofessional interactions. Research has shown that nurses often feel disrespected and undervalued in the workplace (Peter et al., 2004b) and interprofessional conflict is a major source of distress (Manojlovich & Spence Laschinger, 2008). For the nurses to deal with conflict and foster better teamwork, they can participate in

activities that help create a stronger ethical climate, such as holding regular staff meetings, attending workshops and taking continuing education courses. They can also develop conflict resolution skills to approach problems directly.

Furthermore, communication skills are essential to establish and maintain effective working relationships with professional colleagues. These skills require acquisition of 'tools,' such as conflict management, team-building, and effective communication skills to use in discussing ethical issues (Parker, 2007). The power of the nurses, nevertheless, emanates as they commit to the organization by serving as an exemplary role model, innovator, critical thinker, and communicator for the health care team. Maintaining one's power translates to conscious, deliberate, and participative decision making regarding ethical dimensions in practice.

On the issue of powerlessness that has been addressed by participants, Maeve (1994) offers a practical suggestion as to how to approach the feeling of powerlessness in a constructive way. Whilst much of the media's attention and celebration is on medical achievements, Maeve proposes that nursing must begin to acknowledge excellence in nursing work. This is possible when nurses feel valued for their efforts and supported by their colleagues and ward managers. The Canadian Nurses Association (2010, p. 10) summarised an important point:

*Celebrating nursing is not just about making nurses feel better. It is about helping nurses to find the moral courage to stand up for what they need in order to do the job. It is also about giving nurses voice so they can articulate the value of their work, insist on certain practice standards and express their concerns in an effective way.*

One of the crucial points made by Storch and colleagues (2006) was that nurses must not give up hope, and must not undervalue the power of individual and collective action. It is clear that "to improve ethical practice, nurses must work proactively with other disciplines to identify problems in the moral climate in which they practise and to come up with solutions" (Rodney et al., 2006, p. 27). Taking the first step of acknowledging that good teamwork is integral to ethical practice in nursing, then

taking the next steps of working to foster a strong ethical climate, are necessary for the delivery of excellent patient care.

### **10.3.2 Nursing education**

As described in chapter two, whilst ethics education has can have a positive impact on the development of students' moral development, the ethics theory and clinical practice seems disconnected. On the basis of that, there is a need for nursing students to be able to discuss ethical concerns in their clinical practice, and not just focus on clinical competency. Given that the students may lack the confidence to discuss such concerns, the nurses can therefore serve as role models for the students in the course of their clinical practice. According to Cameron et al. (2001) ethical reasoning is best learned in the practical context, with support and guidance for nurses to analyse their attitudes and behaviour. It is not by identifying ethical dilemmas that the skills of ethical reasoning are learned, but by resolving them, and it is likely that clinical experience would be extremely influential in this matter. Auvinen et al. (2004) further demonstrated this, where students who had gained experience in dealing with moral issues during their clinical internment, were at a higher level of moral reasoning than students without such experiences. The importance of clinical practice was neatly summarised by McAllister (2001) who argued that clinical practice is always seen as a vital and exceptional resource in preparing future nurses for their professional role. This is particularly the case when learning in clinical practice provides up to half of the educational experience of nursing students. In fact, the students perceive the practice setting as by far the most influential context when it comes to acquiring nursing skills and knowledge (Chan, 2001).

In addressing the spiritual need of Muslim patients, there is a need of some level of cultural insights amongst the health professionals to highlight certain key teachings in Islamic ethics and its applications in delivery of care. This will not only assist clinicians to better understand the Muslim patients, but also to respect to their beliefs. Halstead

(2007, p.283) postulates that among the main differences between Islamic and western morality are:

*The emphasis on timeless religious principles, the role of the law enforcing morality, the different understanding of rights, the rejection of moral autonomy as a goal to moral education and the stress on the reward in the Hereafter as a motivator of moral behavior.*

Halstead observes that, in the minds of many Muslims, little attempt is made to distinguish between the concept of moral duty and the concept of religious duty. Questions like “What should I do?” or “How should I behave?” may receive both moral and religious answers. Halstead (2007, p. 284) further posits that:

*...many Muslims find it difficult to talk about morality outside the context of religion. In fact, morality in Islam is generally understood as a list of rules, duties and responsibilities whose authority derives directly from the Qur'an and the hadith (sayings and traditions of the Prophet Muhammad and his companions).*

Ethical conduct in Islam “is not expressed in terms of propositions, but rather in terms of divine dictates and actions” (Rahman, 1985, p.18). He further postulates that Muslims should accept the Qur'an as the basis of their ethics because they believe it is the word of God, and that they believe that it “contains, actually or potentially, the answers to all the questions of everyday life” (Rahman, 1985, p. 14). In other words, whilst Brunei is wholly an Islamic nation that does not mean that ethical significance pertaining to healthcare practice should be left as it is, that is without further academic dialogue.

Gamal Badawi (2011) wrote in his article “Muslim attitudes towards end-of-life decisions”, that end-of-life decisions are not made exclusively by an individual person based on beliefs and values. Therefore, as a health professional, he was careful in calling between “an” Islamic perspective and “the” Islamic perspective. Badawi asserts that no person can claim that his or her interpretation is “the” Islamic perspective, which means that a perspective is subject to debate and correction. Therefore, health professionals must begin to explore and reflect the spiritual (Islamic) aspects given to

patients in addressing patient care. At the same time, nurses must also begin to explore multi-faith beliefs on end-life-care decisions.

Meanwhile, there is a serious attention needs to be given on the critical aspect of the nursing education. It is recommended that the nursing programs incorporate explicit treatment of ethical issues within the broad context of professional nursing practice, because this suggestion invites thinking and enhanced awareness of the importance of this area of practice. Such treatment and enhanced opportunities for ethical discourse in the practice setting may be even more compelling for practicing nurses. Training should also seek to make nursing students critical thinkers who are capable of taking control of their thought processes and acquiring an understanding of these processes. A blended learning context can provide the independence and increased control essential to developing critical thinking (Garrison and Kanuka, 2004). Nurses need to critically think through their decisions, be willing to be flexible, and know what they do and do not know, as well as be aware of the many ways to approach a decision (Lewenson and Truglio-Londrigan, 2008). Their vocational training should be based on pedagogy that facilitates learning to inculcate in them codes of ethical conduct and ethical decision making (Gropelli, 2010).

It is important to note that the aim of ethics education for nursing students is to produce morally accountable nurses skilled in detecting and responding to these ethical issues (Gorgulu and Dinc, 2007). Therefore, a course in ethics for nurses has two main aims: to enhance students' understanding and awareness of the ethical demands placed on them by nursing, and to equip them with the ability to respond well to such demands with sound moral judgment (Holland, 1999a).

Whilst there is an urgent need to for educators to prepare the students for ethical challenges in practice, there is also a need to promote confidence amongst students to address and challenge concern or uncertainty in practice. This can be achieved by organising various student learning activities to promote higher confidence amongst

students. The class debate or ethics roundtable discussion, for example, will provide an opportunity for students to reflect their personal and professional values, and thus integrate their valuable insight regarding the ethical issues or challenges in practice, particularly in discussing conflict resolution.

Lacobucci et al. (2012) posits that nurse educators in both clinical and classroom settings should have opportunities to learn current strategies in resolving value conflicts that will support their ability to model professional ethical behaviors when students seek guidance. In other words, nurse educators themselves, particularly clinical teachers (where they can address real-life ethical problems in clinical settings) to play an active role and to be ready to address and welcome ethical discussions or sharing sessions between the students and clinical teachers. Meanwhile Teresa Wehrwein (1996) encapsulate five principles to use in developing an ethical basis for student-teacher relationships. These principles include mutual respect, open communication, demonstration of linkages between ethical principles and behaviour, facilitating students' understanding of their behaviours, and acknowledgement of appropriate individual differences in viewing ethical positions. Furthermore nurse educators should also assess the ethical content in the current curricula to ensure that students are acquiring a practice-specific understanding of ethics and the skills necessary for working within system to improve ethical practice.

### **10.3.3 Nursing policy**

The formulation of the ethical codes and professional conduct indicate a great interest by the Nursing Board in Brunei to address the ethical practice of the nurses in the nation. There appear to be a critical concern that the current code does not offer sufficient detail in assisting the nurses' on how to response to ethical concerns, and therefore does not act as an immediate reference point if a nurse is faced with a particular dilemma or concern. It is suggested that relevant stakeholders, particularly the Board, provide continuous understanding through road shows, lectures, conferences, seminars and



many other initiatives to ensure that the nurses understand exactly what is expected of them. Therefore the Board has to play a proactive role in promoting the nurses' understanding of the principles inside the code of ethics and code of professional conduct. There is also a need to constructively utilise the code of ethics as a framework to initiate discussion on ethical concerns that nurses experience in practice. In this thesis, I chose not to include data relating to the participants perceptions of the new code of ethics since majority of participants appear not interested to further discuss the code for reasons such as "the code is not new to them", "the code is not fully understand", and "I only need to read them for my promotion exam". This led to redundancy in exploring the codes from the outset.

Meanwhile there is a necessity to formulate a policy where educational programs within the ward itself is mandatory. Activities such as workshops and educational sessions within the ward, or throughout the hospital setting, must not be undervalued. These activities are deemed vital to address ethical reflection, hence as a measure to support the highest patient care standards and deliberate diminished quality patient care. This is particularly the case where some of the nurses may have little or no formal ethics education whilst some may have acquired it through continuing education programs. Whilst nurses should take responsibility for their personal and professional growth by continuing their education, there should be some available support in place. For example, ward managers may need to be sufficiently prepared to address nurses' concerns specific to ethical dilemmas within the ward.

Whilst an ongoing education programs is essential to support ethical dialogue in health care practice, there may need be a guidelines or ward policy where health professionals have the opportunity to reflect on a ward incident which may posed as ethical dilemma, for example critical incident, poor care, adverse events, medical error and near miss. In so doing, these will allow professionals to express their concerns and be more vocal and effective in advocating for quality patient care. The policy will also provide an

analysis after such events occurs and is reported. Therefore this will contribute to the learning process of ethical challenges and potentially help to reflect on the multifaceted dilemma. In Brunei to date, there is only one research ethics committee in the main hospital. Strategies suggested by Lachman (2010), such as increasing organisational accountability and developing organisational ethics committees to facilitate ethical discourse and decision making, can help nurses to demonstrate moral courage by speaking up to whenever there is any doubt concerning patient care. It would be proactive to invest in having ward managers as role models who will take forward ethical agenda items in staff meetings.

In the United Kingdom, for example, among other development of structures to monitor and improve professional standards, and to respond to deficits in those standards, is the formation of clinical ethics committees which operates often in an advisory role (Slowther et al., 2001). Such organisations themselves also need to embrace the virtues of moral courage, wisdom, and integrity so that concerns and reports of poor practice are responded to quickly and professionally.

There is also a call for the authority to address the shortages of nurses via the written of policy, particularly in planning the numbers, types and mix of professionals required in the provision of safe ward environment. Given the evidence that such staffing levels are associated with adverse outcomes, systems should be developed for the routine monitoring (Needleman et al. 2002). This may means that hospital administrators and relevant stakeholders need to take rapid action to ensure that an adequate nursing staff is available and adhere to, as a way to protect patients and to improve the quality of care. Whilst the nursing workforce may never have the optimum numbers to meet the needs of patients, the team need to make the best use of each member's education, skill and expertise (Institute of Medicine, 2010).

Implementation of these recommendations, nevertheless, will take time, resources, and a significant commitment from nurses and other health professionals; nurse educators; researchers; policy makers and government leaders and other key stakeholders.

#### **10.4 RECOMMENDATIONS FOR FUTURE RESEARCH**

With regard to the potential limitations related to the methodology, some suggestions for future study have been discussed in chapter five. There is a need for an in-depth exploration of how nurses engage in taking responsibility in responding to ethical dimension and how to influence nurses who opt to shift responsibility to others would be very helpful. Further research could explore the analytical thinking of nurses in making decisions, and explore the leadership role of ward managers, including in-charge nurses, and how collective leadership might support a visible ethical environment and practice.

At the same time, more methodological work is needed on how to robustly capture the impact and outcomes of nurses' involvement in research including exploration of nurses understanding on ethical issues such as end of life care, patient safety and respecting patient's autonomy which are central in today's health agenda.

It would also be very useful to conduct some longer-term studies using different method of data collection such as participant observation whereby it can be utilise to research a culture, practice or situation from within. This observation enable further understanding on how activities and interactions within a setting give meaning to belief or behaviours. For example there may possibly be differences between what the nurses say and what they do when managing the patient care when there is shortage of staff. Such research may describe how moral distress is experienced in nursing practice.

Research is also needed to explore nursing students' insight of what knowledge and skills are essential to achieve a sense of preparedness for ethical decision making in their role. Such exploration may provide understanding into factors that may increase

the self-confidence when facing an ethical dilemma. Other recommendations for future research on ethical responsibilities include the validation of Kohlberg's theory for nursing investigations, examination of other available frameworks for developing a multidimensional view of ethical responsibilities, and the use of both quantitative and qualitative research designs. Additionally, considering the additional recommendations for future research in this study, research might be conducted in other hospital settings in Brunei to further understand the reflective views of nurses in other context.

## **10.5 CONCLUSION**

The origin for this research emerged from concern about the ethical practices of nurses in Brunei, after the establishment of professional conduct and ethical codes. Informed by this interest, the study has shed a light on the nurses' description and understanding of the ethical dimension embedded in their practice, and how they have responded to such dimension in practice. The findings of this thesis have identified the ethical dimensions of nursing in Brunei, and the nurses' responses are revealed in the strategies those nurses employed in the avoidance of conflict and maintenance of harmony in practice. The developed core category, 'negotiating ethical responsibility', has facilitated additional understanding of how nurses in Brunei described the ethical dimension in their daily practice, and their responses, through the employment of several strategies. With this findings, it is anticipate that further support is needed for nurses to be aware of the ethical dimension in their practice and to respond to ethical concerns accordingly.

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## **Appendix A: Ethics within the curriculum**

### **Semester 4 (Year 2)**

#### **Unit 4:3 Legal and Ethical Issues**

**Description:** This unit will provide the knowledge and skills in the legal and ethical issues in nursing. This will enable the nurse to apply knowledge and skills in their professional role in relation to moral decision making. This will also increase their capacity to be accountable and be responsible for safe practice.

**Total Hours:** 30

**Credit:** 1

**Outcomes:** On completion of this unit, the student should be able to:

1. Describe the subject matter of ethics and the relevance of ethics and methods of use in relation to morality.
2. Describe a decision making framework used in resolving ethical nursing problems.
3. Recognise the importance of personal values and beliefs, professional moral standards, moral concepts and the ethical principles to base a decision making framework in relation to moral decisions and actions for nursing practice.
4. Recognise the importance of the professional code of conduct to base nursing practice and to safeguard the public.
5. Recognise the importance of ethics in the professional role of the nurse.
6. Recognise the relevance of ethics in the Islamic perspective and its importance to nursing.
7. Recognise the Nurses' Registration process in Brunei Darussalam.
8. Give a broad outline of the history of law.
9. Describe the Brunei Darussalam court system including the religious (shari'ah).
10. Define legal terminology.
11. Explain negligence and consent and other legal concepts related to nursing.

#### ***Unit content***

##### **Introduction to Legal and Ethical Issues**

The discipline of ethics

Basic terminology

Ethical codes in nursing

##### **Code of Professional Conduct – United Kingdom Central Council for Nursing, Midwifery and Health Visiting**

International Council of Nurses – Code for Nurses (ICN).

### ***Ethical Principles***

Beneficence  
Justice  
Autonomy  
Fidelity  
Veracity

### **Ethical Concepts for Nursing Practice**

Advocacy  
Accountability/Responsibility  
Cooperation  
Caring

### **Nurses' Registration in Brunei Darussalam**

The Brunei Nursing Board

### **The Value of Dignity and Human Life**

Informed consent  
Patients' Bill of Rights

### **Nurses and Patients**

Confidentiality  
Withholding information  
Disclosing information  
Truth-telling

### **Nursing Ethics throughout the Lifespan, Including Specific Issues**

In the procreative family  
In the care of the children/adolescents  
In the care of adults  
In the care of the aged  
In the care of the dying

### **Influences on Ethical Decision Making**

Philosophical  
Cultural  
Religious social  
Political  
Individuality of the patient

### **Ethical Considerations in Nursing Research**

Ethics and nursing research  
Aspects of ethics and research  
Implications of ethics and research  
Issues relating to the use of human subjects in research

### **Ethics in Islam and Its Relevance to Nursing**

**The Legal System in Brunei Darussalam**

Courts, religious law, common law, civil law, criminal law

Assault, battery, false imprisonment, negligence, trespass, consent, defamation

Legal considerations affecting health care

**Teaching And Learning Processes:** Lectures, group work, seminars, seminars, discussions

**Assessment:** Assignment of 1000-1500 words (100%)

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## **Appendix B: Interview Guide**

Introduction: Thanks for being here today. As mentioned before, I am really interested in talking with you about your experiences and thoughts on the sort of difficulties you come across being a nurse, particularly from your day-to-day nursing practice. My study looks at how ethical problems present themselves for the nurses, what nurses would describe as ethical problems and their responses to them.

### **Initial Open-Ended Questions**

1. What normally happens during your shift?
2. How would you describe your job as a nurse?
3. What made you want to be a nurse?

### **Intermediate Questions**

1. Could you describe the most uncomfortable situation that you have experienced or encountered in practice?
2. How did you attempt to respond to that situation?
3. Why did you respond in that way?

### **Ending Questions**

1. How would you describe 'ethical problems'?
2. What are your personal views about our new codes of ethics?
3. Do you have any other views or comments on this topic which we have not talked about so far?

Closing: Thank you very much for taking your time to come and talk with me today. I really appreciate you giving up almost 90 minutes of your time to be part of the study.

## Appendix C: Sample of coded transcripts

Description of Interview	
Venue	RIPAS Hospital
Name of participant	Daud
Gender	Male
Marital status	Married
Years of working	More than 10 years

<p>I never thought of being a nurse. After O Level, I wanted to further my study, but I don't have my English O Level. Everything needs English, but eventually I got an offer nursing. Nursing is not really my interest. Nevertheless, I try to give my best in caring for patients.</p>	Interest in nursing
<p>When I was in medical ward, workload is far more organised if there is a key person responsible in the allocation of tasks. But if there is no key person, it can be chaotic.</p> <p>They can't finish doing the vital signs. Not even the fluid chart. They work for the doctors, and not with the doctors. These nurses were far more concerned if the doctors questioned the reasons they can't finish the task given. We can't focus on our job since there are so many orders from doctors. We are looking at the patient's need as a whole. So many things that need our attention.</p> <p>I feel like my head going to explode, especially when being put as in charge. At times, we couldn't manage.</p>	<p>Delivery of care</p> <p>Selfish Work for doctor</p> <p>No focus</p>

I did say in a meeting that, the doctors are angry because patient is not ready to be seen. Everything is messed up; patient is not sat up on chair.	Doctors get angry
We have Neurology patients. They need a lot care, but the staff is just not enough.	Understaff
There is less teamwork. There is no focus really.	Less Teamwork
We had an incident before where we received a patient from another hospital. The patient had stroke. It was an afternoon shift, and there were only 3 nurses working. I was pretty much newly qualified at that time. Patient came with restlessness, on urinary catheter and was put on Mannitol stat.	Restless patient
<p>I did the admission. The patient's blood pressure was high. I checked the BP just before I left the ward. There was no order from doctors whether patient needs BP monitoring. It was up to us to the nurses. There was no order on Neurological observation as well.</p> <p>The next morning, I became the in-charge again. The patient got transferred to medical ICU around 9am. The patient was with us in less than 24 hours. In a week or two, he passed away. We were being called by the administration, trying to find out what actually happened. I just explained what I did during those shifts.</p> <p>The patient was somebody important. It was treated as a special case. I believe the incident became out of proportions. We were blamed as the patient had to have a tracheostomy inserted whilst in the ICU. We don't know why we were blamed. Until today, I still questioned myself why we were still blamed.</p>	<p>No medical order</p> <p>Being questioned</p> <p>Blamed</p>

<p>I don't know why we were blamed. I feel so unsatisfied. It involves lots of writing letter, trying to explain what actually happened.</p> <p>Patient's family was ok. It is our 'own people' who blamed us; they should have cover and support us. I mean, how you would feel. It was still a question mark really until now. I don't know what happened to them. I mean, even small problems, we are being blamed.</p>	<p>Blamed</p> <p>Our own people should support the nurses</p>
<p>Another incident is when a patient with GI Bleed. He was restless; we restrained him as he was pulling the NG Tube. He was then transferred to ICU for about 2 months. While in ICU, put under Neuro, patient was put on DNR. Just waiting for the time, so they normally are transferred to general ward. DNR means, nothing much can be done. Poor prognosis.</p> <p>He was put admitted to our ward. Patient got into cardiac arrest. Family somehow changed their mind; they wanted us to do the CPR. He was transferred back to ICU, despite of the DNR status.</p> <p>From the outset, the daughter wanted the father to be kept in ICU. Anyway, once the DNR status reconfirmed, patient passed away in the medical ward. After two days or so, the matron came. We were asked to come up with an explanation. He wants to know what happened.</p>	<p>DNR incident</p> <p>Family role in making decision</p> <p>Being questioned</p>
<p>For me, the challenges of being a nurse, first; if family doesn't understand our job; secondly, if doctors who just want us to follow what they want. It is not so much to do with the patients really, as they are unwell. Thirdly, when patient families are not supportive.</p>	<p>Challenges being a nurse</p>

<p>With doctors, sometimes they asked the nurses to do it. Doctors will ask us to get everything ready. They will ask us; can you call for me this and this person for an urgent scan? I don't that's our job. For an urgent CT Scan, the doctor must ring the radiologist. Then, there is another one about portable echo. Some doctors don't understand how things work. They want things to be done quickly. So I just need to explain how the procedures are done.</p>	<p>Doctor's role</p>
<p>I don't argue with doctors. When they write orders, I normally ask why. I mean, they want everything to be done quickly. I have to explain things to the doctors, in a nice way. There was one time; I got a patient on Isoket, check the BP reading which pretty much the same is for quite a while.</p> <p>I asked a senior nurse who is also a friend, about Isoket protocol. I rang the doctor and enquiry about this, talking about standard protocol. It's like, nobody notice about this.</p> <p>The doctors agreed, order the new dosage, and would sign the chart later.</p>	<p>Noticed something wrong</p> <p>Make enquiry Confirmed with senior nurse</p> <p>Doctor listen</p>
<p>I don't know why it didn't get notice. I mean human beings make mistake. They just follow the doctors' orders. They work for the doctors. For me, we work with doctors, not for them. We work for the patient's benefits.</p>	<p>Do we work for the doctors?</p>
<p>I said something because I know. This thing, perhaps something to do with experience.</p> <p>Like last time, one patient was put on both Losec and Ranitidine for many days. It's the same medicine, you see. Again, nobody notice. I made some inquiry to one of the doctors who were also unsure. After doctors round, I asked the doctor who did the order, he admitted the mistake. But you see, its patient who are affected.</p> <p>That's why we need to ask and inform the doctors if we are unsure. We can see the difference if one is working with the doctors, and one is working for the doctors.</p>	<p>Experience helps</p> <p>Made enquiry</p> <p>Working with doctor vs working for doctor</p>

<p>Being a nurse is a stressful job. Say in a shift, only 3 staff in morning and 3 staff in afternoon. Then we have one office hour, just a runner. About 8am or 9am, the office hour nurse would be called up for a meeting, endless meeting.</p> <p>We sometimes managed, sometimes we don't. We just have to tell the doctors about this, otherwise it's just impossible.</p> <p>And to be honest, at times, I even thought of quitting the job.</p>	<p>Environment</p> <p>Managing the workload</p> <p>Quit the job</p>
<p>I stay because I would like to make changes, as much as I can. Of course, not everyone going to be happy. I mean those charts like I/O and TPR should be documented accordingly. Also, I think we have to be careful when we delay some of the tasks. It may not get done, you see. Say TPR, it's not done properly, only once a day. Maybe they don't see the important of it. They don't see that important of patient care. I mean, after following doctor's order, then that's it. That's done. For me, we need to talk to our patients.</p> <p>We must try to talk to patients, as much as we can. I mean, our workloads are so much, but we can do things 2 in 1. No matter how busy, I still do it.</p> <p>We eat and rest, but we still carry out patient care. And there's paperwork too. Some seems unnecessary. I know some nurses just 'chart down' on the two hourly patient turning, yet it was not actually done. You see, we are busy, but that does not mean that we can underestimate patient's safety.</p>	<p>Patient care</p>
<p>There is a lot of paperwork, sometimes it is unnecessary. What's the difference between doing, but not charted, compared it with charted but not doing them? For example, 2 hourly turning etc.</p>	<p>Paperwork</p>

<p>When it comes to the Assistant Nurse, I think nowadays people talk about assistant nurse can no longer give medicine unless in emergency cases. It's to do with the policy. Patients would not know whether there are Assistant or Staff nurse. They are still nurses.</p> <p>Although they (Filipino nurses) are assistant nurses, they are also qualified with degree. I don't understand. There are assistant nurses who become ward in-charge, do reports and many others. Yet they are not allowed to prepare and administer medicine.</p>	<p>Role boundaries</p>
<p>I think the public still see us nurses are like their maid. Everything we have to do</p>	<p>Nurse status</p>
<p>Cleaning the patients. I mean, the family can do it at home, but once in the hospital, the families automatically don't know how to do it. For me, I will just get them involved. Not only that, nurses are not respected. I mean, hospital is where the nurses work yet it's not respected. People sit on our nurses' station. The visiting hours are not respected. Family and doctors just give orders.</p> <p>I mean, in one occasion, when we wanted to break our fast (in Ramadan), there was this Chinese family, asking us to clean the father (BO). When we explained, he got angry, we can get into fight. We will be lectured; they won't be asking the patient.</p>	<p>Expectation on family</p> <p>Not respected</p>
<p>There is not really any support from the ward sister. They should be the one to stand up for the nurses, don't just blame the nurses so easily. Do investigations. Don't just jump to conclusion.</p>	<p>Support from ward sister</p>

Nursing can be stressful job, but again, it all depends on the ward, especially if no teamwork.	Teamwork
All the patients need our attention, maybe because of we are understaff, hence the stress feelings.	Understaff
In term of the status of the doctor, I think doctors are still up there, but maybe now it's getting better, since we have more local Bruneian doctors.	Better relationship



## Appendix D: An Example of the development of a refined category—

### Nurse and doctor

This appendix uses the conceptual category ‘The relationship’ as an example to demonstrate the development of a category in the coding process from the raw data, Initial Coding to the category at Focused Coding.

Translated Transcripts	Initial Code	Concept	Conceptual Category in Focused Coding
<p>Doctors are still up there, but maybe now it's getting better, since we have more local Bruneian doctors. Things are getting better nowadays (Extract 7)</p> <p>The graduates hold a degree abroad. There's no difference from the doctors. In a way, they are in a better position to communicate for us. They can challenge the doctors. (Extract 9)</p>	<p>Better relationship</p> <p>Graduate nurses</p>	<p>Working relationship</p>	<p>The relationship</p>
<p>I have a good professional relationship with the doctor. I share my view about the patients. I always show my staff, how to speak to nurses when there is any conflict or disagreement. There is a way to it. (Extract 17)</p>	<p>Professional relationship</p>		
<p>It such a nice feeling when the doctor hear you, listen to your suggestion on patient care. It feels good, to be honest. They appreciate you as a team member. (Extract 9)</p>	<p>They listen to nurses</p>		

When they get angry and it is not our fault, we just smile, keep quiet and accept it. We simply listen. I mean, there are time where I feel I want to say what's on my mind, but I tend to just keep quiet (Extract 1)	Keeping quiet	Communication	
When you saw your friends being treated that way whilst she tried to voice out on nurses' rights, they were being condemned instead. There is no communication with each other in the ward. It is difficult. (Extract 11)	No communication		
There are nurses who don't like doctors because the doctors look down on them. It is true. Sometimes doctors like to humiliate the nurses. They always think of their 'class'. They shout and caution nurses in front of others. They think nurses are stupid. They would ridicule our ability by saying 'oh, so you don't know?' Nurses then become defensive and humiliated. We are not supposed to humiliate people, right? I was once viewed as not knowing anything by the doctor (Extract 10)	Look down on nurses	Status	

<p>Some doctors are fine. Some make demands, asking the nurse to get the medical note for them, or the treatment chart. They will be saying ‘okay you do this, and do that’ but they are not clear what actually they are asking. This usually happen if the doctor disagree to each other decision. So confusing for us nurses and patient. (Extract 23)</p>	<p>Make demands</p>		
<p>Nurses have to chase after them. It’s so annoying. We have to open the medical case note which is right in front of them! It is funny because we have to do that for them? (Extract 1)</p>	<p>Chase after them</p>		

## **Appendix E: An example of memos – Initial Code ‘workload’**

‘Workload’ emerged in all the conversations with the participants as one of the concern that described in their daily practice. The workload is evident in terms they used such as being busy, having to attend doctors, too much to do, understaffing and a lot of orders from the doctors. ‘There is too much to do, with not enough staff’ is the common workload concern underlying nursing practice, as indicated in Aziz’s words (extract 16) ‘higher workload’, which creates a stress amongst the nurses.

Further analysis revealed that there were a range of meanings in relation to this focused code, depending on the orders, the practice environment; teamwork amongst the nurses, reduced time with patients and management of workload.

The workload is heavily comprised of carrying out medical orders, where nurses’ were feeling the pressure of trying to complete such orders. Latifah (extract 1) described that such orders can be a source of problems for the nurses such as when doctors made a verbal order. The need to complete the orders was frequently mentioned by the participants. Regardless of the workload, the participants feel that teamwork is the key to manage the workload. Daud (extract 7) said whilst the job can be stressful, if there is teamwork, then it can makes the workload lighter. Teamwork is the key, according to some participants.

There are a number of implications from the heavy workload. Some participants disclosed incidents of wrong drug administration as a result of heavy workload. According to Maimunah (extract 28), medication errors are increasing in the last ten years. The heavy workloads were also associated to reduce the time spent the communication with patients, doctors and nurse colleagues. This is evident when nurses are too focused on their own tasks. The interaction with patients takes place during the doctor’s round, or when they performed procedures such as checking patient’s vital signs. Mariani(extract 9), for example, said “It all depends on the shift. If I were too busy, the communication is rather restricted to important matters”.

## Appendix F: Summary of the coding process

This appendix provides a summary of the coding process, showing a link from the development of the Initial Coding to the conceptual categories at Focused Coding, and to the refined categories at Theoretical Coding.

Initial Coding	Focused Coding	
Open codes	Conceptual categories	Refined categories
Nursing care delivery	Nursing work	Nurse at work
Nursing tasks		
Job description		
Understaffing	Ward environment	
Workload		
Working relationship	The relationship	Nurse and doctor
Communication		
Status		
Medical orders	Role of a doctor	
Professional judgment		
Teamwork		
Good and difficult patient	The patient	Nurse and patient
Patient care		
Nurse and status		
Consent	Interest of the patient	
Communicating bad news		
Role of family		
Getting help	Taking responsibility and Shifting responsibility to others	Strategy: Taking responsibility
Raising concern		Strategy: Shifting responsibility
Denying authority		
Keeping quiet		Conflict— Harmony Paradigm
Consequences of action		
Patient interest		
Right thing to do		
Maintain good relationship		
Lack of authority		

## Appendix G: Ethical Approval



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Bandar Seri Begawan BA1710  
Negara Brunei Darussalam

Our Ref MHREC/EDU/2011/43(26)

12th November 2011

16th Zulhijah 1432

Yusrita Zolkefli  
School of Health in Social Science  
The University of Edinburgh  
Medical School  
Teviot Place  
Edinburgh  
EH8 9AG  
United Kingdom

Dear Yusrita,

### Re: Senior Nurses' Perceptions of Ethical Problems

Thank you for applying for ethical review of your proposal entitled above. All documents that you have provided were reviewed.

The MHREC has approved your study from the ethical perspective. This approval is given for the proposed duration of your study or one calendar year from the date of this letter whichever is shorter. If you are unable to complete your study within this period, please submit an application for extension at least 2 months before the expiry of the original MHREC approval. Please notify the MHREC of any changes to the design of your study and inform us immediately of any adverse incidents.

would like to wish you all the best with your study and would be grateful if you could forward us a summary of your findings for our records.

*Together towards a Healthy Nation.*



**Dr Alice Yong Moi Ling  
Deputy Chairperson of  
Medical and Health  
Research & Ethics Committee**



Cc Director General of Medical Services, Dr Hj Rahmah Hj Md Said  
TAT/AYML

## **Appendix H: Study information sheet**

1. Letter to Hospital Administrator
2. Study information sheet (English version)
3. Study information sheet (Malay version)

Yusrita Zolkefli  
Student ID: s123456  
The University of Edinburgh  
Telephone: 123456789

Email: 123456@gmail.com

RIPAS Hospital  
Bandar Seri Begawan BA 1710

21st November 2011

**To whom it may concern,**

**Re: Request for room booking**

My name is Yusrita Zolkefli and I am a doctoral student at the School of Health in Social Science at the University of Edinburgh. I am planning to conduct a study in December 2011 and April/May 2012, and my research participants will be staff nurses who work in RIPAS hospital wards.

In order for the interview sessions to take place, I would like to request a quiet room in the hospital area. Since the dates and times for these room bookings are subject to the availability of the nurses, confirmation can only be given at least 24 hours before the actual interviews.

Enclosed are the ethical approvals both from the University of Edinburgh and Medical and Health Research Ethics Committee (MHREC) Brunei. Should you need any further information, please do not hesitate to contact me directly (phone 8889977 or email s0977143@sms.ed.ac.uk)

Your support for the study is very much appreciated. Thank you for your consideration.

Yours sincerely,  
Yusrita Zolkefli



## **Study Information Sheet for Participant (English version)**

### **Purpose of the research**

The research sets out to explore how ethical problems present themselves for the nurse mentors, specifically how they define or perceive ethical problems in order to inform how these may influence their nursing practice.

### **Types of research intervention**

This qualitative research will involve nurse participation in an in-depth personal interview lasting no longer than 90 minutes.

### **Participant selection**

You are being invited to take part in this research because your experiences as a nurse mentor will contribute much to the understanding and knowledge of nurses' ethical practice.

### **Procedures**

You will be able to select the day and timing of the interview (between week 2 and week 3 of December 2011), preferably before your shift starts or during your day off.

Interviews will be held in a quiet room around hospital area, in private, on a one-to-one basis. The entire interview will be audio recorded.

### **Confidentiality**

The contents of the interview will be treated with complete confidentiality, the information being available only to the principal investigator and her immediate supervisor.

To ensure anonymity, each participant will be allocated an identification number. The names of those being interviewed will only be available to the principal researcher.

All collected data will be stored in a secure placement accessible only to the principal investigator.

### **Sharing the results**

The research findings will be shared through publications and conferences so that other interested people may learn from the research. Should you be interested to know the findings, you may request to do so upon the completion of the study.

### **Right to refuse or withdraw**

Participation in this research is entirely voluntary. Prospective participants may decline to partake without any explanation for that decision. They may also withdraw at any stage without explanation.

**Financial reimbursement**

No fee will be paid or no incentive will be given to the participants.

**Who to contact**

If you have any questions, you can ask them by contacting the principal investigator.

Telephone: 8889977

Email: s0977143@sms.ed.ac.uk

The research protocol has been reviewed and approved by the Medical and Health Research Ethics Committee, and by the Ethics Review Committee of the University of Edinburgh.

## **Study Information Sheet for Participant (Malay Version)**

### **Tujuan penyelidikan**

Penyelidikan ini bertujuan untuk meneroka bagaimana masalah etika/moral yang dihadapi oleh para jururawat, khususnya bagaimana mereka menentukan atau menyedari sesuatu masalah etika itu. Ini akan dapat memberi kefahaman bagaimana masalah tersebut boleh mempengaruhi amalan kejururawatan mereka.

### **Jenis penyelidikan**

Penyelidikan kualitatif ini akan melibatkan penyertaan jururawat dalam satu temubual yang berlangsung tidak lebih daripada 90 minit.

### **Pemilihan peserta**

Biskita dijemput untuk mengambil bahagian dalam kajian ini kerana pengalaman biskita sebagai jururawat. Penglibatan biskita nanti akan menyumbang kepada pemahaman dan pengetahuan amalan etika jururawat.

### **Prosedur**

Biskita akan dapat memilih hari dan masa temubual (minggu pertama hingga minggu ke-tiga di bulan Disember 2011), sebaik-baiknya sebelum biskita memulakan afternoon shift atau semasa biskita day off. Temubual secara one-to-one ini akan diadakan di dalam satu bilik di sekitar kawasan hospital. Temu duga akan dijalankan dalam bahasa Inggeris, bagaimanapun, jika biskita lebih selesa untuk temuduga dijalankan dalam bahasa lain (Melayu), biskita boleh berbuat demikian. Seluruh temubual juga akan dirakam secara audio.

### **Confidentiality**

Semua maklumat daripada temubual ini akan dikendalikan dengan penuh kerahsiaan dimana data yang diterima hanya untuk penyelidik dan penyelia penyelidik. Untuk memastikan tidak ada sebarang nama sebenar disiarkan, setiap peserta akan diperuntukkan satu nombor pengenalan. Nama-nama mereka yang ditemubual hanyalah untuk pengetahuan penyelidik sahaja. Semua data yang dikumpul akan disimpan dalam penempatan yang selamat yang hanya boleh di akses oleh penyelidik sendiri.

### **Berkongsi hasil penyelidikan**

Hasil penyelidikan akan dikongsi melalui penerbitan dan persidangan supaya orang lain boleh mempelajari daripada penyelidikan ini. Sekiranya biskita berminat untuk mengetahui hasil penyelidikan, biskita boleh meminta untuk berbuat demikian apabila kajian sudah selesai dibuat.

### **Hak untuk menolak atau menarik balik**

Penyertaan dalam penyelidikan ini adalah sepenuhnya sukarela. Biskita boleh menolak untuk mengambil bahagian tanpa perlu memberi penjelasan untuk keputusan itu. Biskita juga boleh menarik diri pada mana-mana peringkat penyelidikan tanpa perlu memberi penjelasan.

**Bayaran kewangan**

Tiada insentif berbentuk kewangan akan diberikan kepada peserta.

**Untuk Dihubungi**

Jika biskita mempunyai sebarang pertanyaan, biskita boleh menghubungi penyelidik melalui talian mobile 8889977 atau menerusi e-mel [s0977143@sms.ed.ac.uk](mailto:s0977143@sms.ed.ac.uk)

Protokol penyelidikan telah dikaji semula dan diluluskan oleh Medical and Health Research Ethics Committee (Hospital RIPAS) dan melalui Ethics Review Committee (University of Edinburgh)

## Consent Form for Research Participants (English Version)

I, \_\_\_\_\_ (name printed) consent to participate in the in-depth interview conducted by Yusrita Zolkefli (PhD student).

I understand that the purpose of this study is to explore the how ethical problems present themselves for the nurses.

I understand that the interview will not last longer than 90 minutes and will be held at a time and location convenient for me. Participation in this study will have no direct benefits for me. However, the information gained in this study may help nurses and future nurses in understanding their own ethical practice in the care of patients in general wards.

I understand that the interview will be recorded. This recording will be used for research purposes only and audio files or transcripts will be destroyed after the completion of the study.

I also understand that if I do not take part in the interview, my refusal will not have any negative consequences for me.

I also understand that I am free to refuse to answer specific questions without giving any reason and am free to withdraw my consent or participation at any time.

I understand that it is likely the findings will be published after the completion of the study and that I will not be identified by name in any subsequent publication. A copy of the findings will be available to participants at their request after the completion of the study. I was given the opportunity to ask any arising questions and these questions have been answered to my satisfaction. Should I have further questions or concerns, the researcher (Yusrita Zolkefli) can be contacted at 8889977 email s0977143@sms.ed.ac.uk

Participant:

Researcher:

Date:

## **Participant Consent Form (Malay Version)**

### **BORANG KEBENARAN UNTUK PESERTA KAJIAN**

Saya, \_\_\_\_\_ (sila tulis nama biskita dengan jelas) bersetuju mengambil bahagian dalam temu bual yang akan dijalankan oleh Yusrita Zolkefli (penyelidik). Saya faham bahawa tujuan kajian ini adalah untuk meneroka masalah etika/ moral yang dihadapi oleh para jururawat.

Saya difahamkan bahawa sesi temubual ini akan mengambil masa selama lebih kurang 90 minit dan akan dijalankan mengikut hari dan masa yang ditetapkan oleh saya.

Penyertaan dalam kajian ini tidak akan memberi sebarang faedah secara langsung pada saya. Walaubagaimanapun, maklumat yang diperolehi dalam kajian ini boleh membantu para jururawat untuk memahami amalan etika dalam penjagaan pesakit secara umum.

Saya difahamkan bahawa kesemua informasi verbal semasa sesi temu bual akan dirakam, ditranskrip dan dianalisis sebagai bahan kajian. Bahan kajian tersebut akan dimusnahkan sebaik sahaja tesis ini selesai dibuat. Selain itu, saya juga mengerti bahawa penglibatan saya adalah secara sukarela dan keengganan saya untuk mengambil bahagian di dalam sesi temu bual tidak akan memberi sebarang kesan negatif pada diri saya. Saya juga mengerti bahawa saya bebas untuk tidak menjawab soalan-soalan yang diajukan dan bila-bila masa sahaja saya boleh menarik diri dari kajian ini tanpa perlu memberikan sebarang sebab.

Saya faham bahawa hasil penyelidikan ini akan diterbitkan selepas selesai kajian dan saya tidak akan dikenal pasti dengan nama saya dalam mana-mana penerbitan seterusnya. Salinan hasil daripada kajian ini akan diberikan kepada para peserta selepas selesai kajian jika memerlukannya. Saya telah diberi peluang untuk mengajukan soalan yang berbangkit dan soalan-soalan tersebut telah dijawab dengan baik dan lengkap. Jika sekiranya saya mempunyai sebarang pertanyaan, saya boleh menghubungi penyelidik (Yusrita Zolkefli) di talian 8889977 atau menerusi e-mel s0977143@sms.ed.ac.uk

Peserta:

Penyelidik:

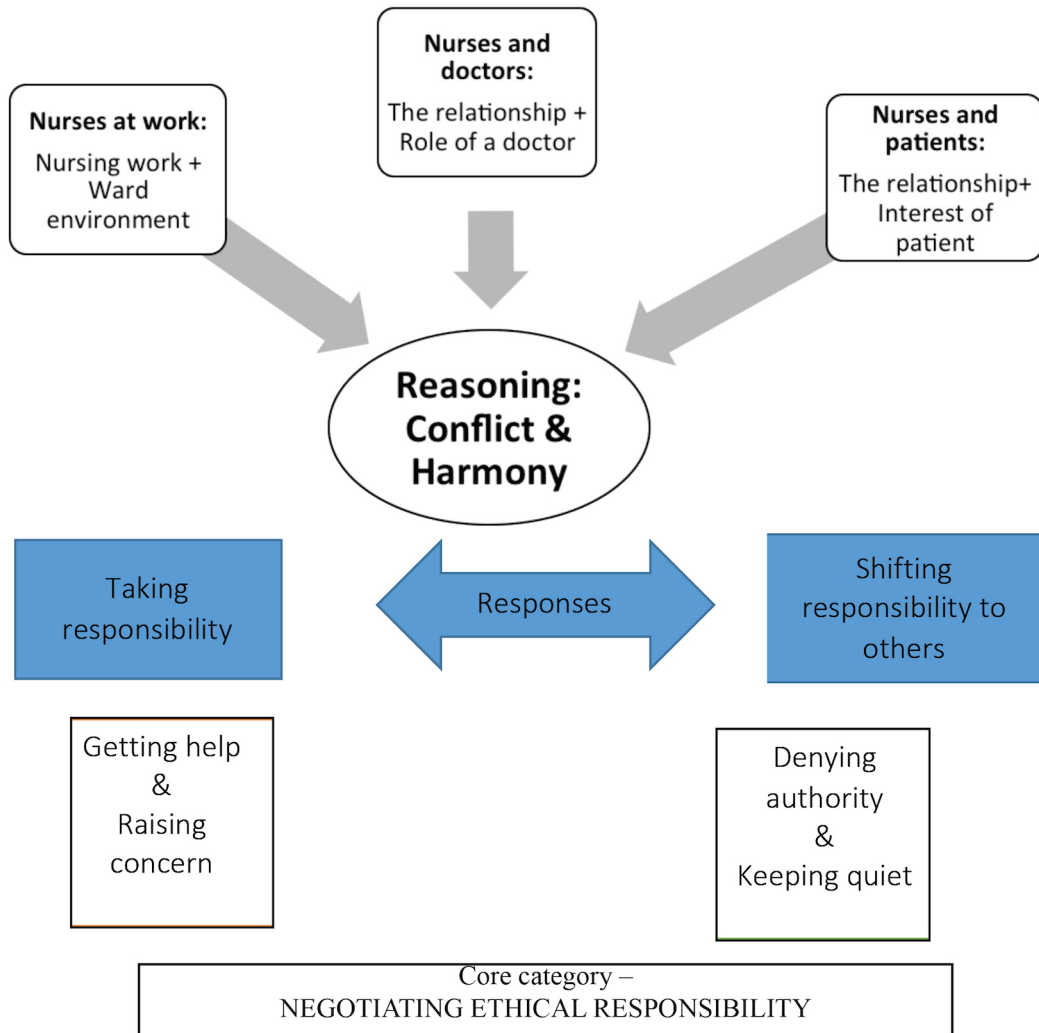
Tarikh:

## List of Figures

Figure 1: Relationships of the Core Category and Categories  
Key concepts generated by data

➡	Nurse at work	Nurse and doctor	Nurse and patient
➡	Taking responsibility And Shifting responsibility to others		
➡	Conflict and harmony		
➡	<b>NEGOTIATING ETHICAL RESPONSIBILITY</b>		

Figure 2 Core category - “negotiating ethical respisibility





## List of Tables

Table 1: Research structure	
Epistemology	Constructivism
Theoretical perspective	Symbolic interaction
Methodology	Constructivist grounded theory
Methods	In-depth individual interview (semi-structured)

Table 2 Profile of the Participants

NO	NAME	GENDER	POST	AREA OF WORKING	YEARS OF WORKING
1	Latifah	Female	Staff Nurse	General Ward	+10
2	Zaitun	Female	Staff Nurse	General Ward	+10
3	Sarimah	Female	Staff Nurse	General Ward	-10
4	Ramlah	Female	Staff Nurse	General Ward	+10
5	Normah	Female	Staff Nurse	General Ward	+10
6	Rosnah	Female	Staff Nurse	General Ward	+10
7	Daud	Male	Staff Nurse	General Ward	+10
8	Samsudin	Male	Staff Nurse	General Ward	+10
9	Mariani	Female	Staff Nurse	General Ward	-10
10	Mariam	Female	Staff Nurse	General Ward	+10
11	Ramli	Male	Assistant Nurse	General Ward	+10
12	Saadiah	Female	Staff Nurse	General Ward	+10
13	Fauziah	Female	Staff Nurse	General Ward	+10
14	Omar	Male	Staff Nurse	General Ward	+10
15	Rafidah	Female	Staff Nurse	General Ward	+10
16	Aziz	Male	Staff Nurse	General Ward	+10
17	Junaidah	Female	Nursing Officer	General Ward	+10
18	Aini	Female	Staff Nurse	General Ward	+10
19	Halimah	Female	Assistant Nurse	General Ward	+10
20	Faridah	Female	Staff Nurse	General Ward	+10
21	Sanisah	Female	Staff Nurse	General Ward	+10
22	Masnah	Female	Nursing Officer	Administration	+10
23	Kalsom	Female	Staff Nurse	General Ward	+10
24	Khadijah	Female	SNO*	Administration	+20
25	Azean	Female	SNO*	Administration	+20
26	Saloma	Female	Nursing Officer	Administration	+10
27	Fatimah	Female	SNO*	Administration	+20
28	Maimunah	Female	Nursing Officer	Administration	+10

\* Senior Nursing Officer